Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

annual report and accounts 2011/12

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

Birmingham and Solihull Mental Health NHS Foundation Trust
Annual Report and Accounts 2011/12

contents

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, 2011 to March 31, 2012.

The past year presented a mix of challenges and changes that affected the NHS, but we have worked hard to improve our trust so that it provides the most appropriate treatment for people with mental health problems in the best possible environment.

During 2011/12, our commitment to improving our services continued with the implementation of the Rapid Assessment, Interface and Discharge (RAID) service at City Hospital in Winson Green, Birmingham, as its ability to reduce waiting times, improve patient outcomes and save money received national recognition.

Dr Hugh Griffiths, the Government's mental health tsar, met the service's pioneering team of clinicians at City Hospital in April, and in January his colleague Professor Alistair Burns, the national clinical director for dementia, delivered a key note speech at our first RAID conference, which was held at the International Convention Centre in Birmingham.

Following its successful pilot phase, the service received further funding to continue its work at City Hospital. By the end of the financial year, the service model for RAID was being implemented at four other NHS hospitals in the region.

Innovative services like this are often born from a need to address a problem, and our staff continued to come up with creative – and in some cases, award-winning – solutions.

Staff from our estates and facilities, dietetics, and occupational therapy teams won two national awards for their innovative approach to improving the choice and quality of patients' food.

Their success at the Health, Estates and Facilities Management Association's Good Practice Awards in April, and the Building Better Healthcare Awards in November, showed what could be achieved, in light of a spate of stories highlighting poor nutrition at some of the country's NHS hospitals.

Good nutrition and choice of meals was just one of the many factors to consider in a patients physical and mental wellbeing, which are at the heart of our newest facility – the Juniper Centre in Moseley – which was officially opened in June.

Without hesitation, deviation or repetition Nicholas Parsons, presenter of Radio 4's Just A Minute officially opened the Juniper Centre in Moseley on June 1. He was joined by the Lord Mayor of Birmingham, Councillor Anita Ward, as they met some of our service users at the event.

The £17.7m, 54-bed facility is a unique development which sits next to existing physical health services for older adults, provided by Birmingham Community Healthcare NHS Trust. Our new hospital is a specialist centre where stroke services, rehabilitation and diagnostic facilities for managing physical and mental health services for older people are brought together on the same site.

Our trust also saw a change on its board when Professor Peter Marquis retired from his role as the trust's chairman in September. Sue Davis, CBE – former Chair of Sandwell and West Birmingham Hospitals NHS Trust (SWBH) – was formally appointed as Chair of BSMHFT in November, following an extraordinary meeting of the Assembly of Governors.

Partnerships, in particular forging new relationships with NHS and third sector organisations, were a strong feature of the year.

In May, the trust signed an agreement with the Birmingham Repertory Theatre and The Hearth Centre to use drama to

promote mental wellbeing. The three partners will work together to share their skills, expertise and resources to encourage service users to engage in arts-based activities and to help reduce the public stigma around mental health.

Another artistic collaboration was sealed in December, when the trust signed a memorandum of understanding with social development agency Sound It Out, to formally recognise our shared commitment to provide people with opportunities in music, whether that involves blowing their own trumpets or singing a new song.

Sound It Out has a long track record for delivering high quality development programmes that often give people with no or limited access to musical education or instruments the opportunity to work with musicians across the West Midlands.

A third agreement was signed in January, as we joined forces with Birmingham Children's Hospital NHS Foundation Trust to improve mental health services for young people across the city.

Both trusts signed a partnership agreement as a commitment to strengthen services to improve the care received by children, young people and their families. We have been working closely to provide an intensive home support service to young people with the most enduring and serious mental health problems. This work has already resulted in more children across the city getting the care they need closer to home, rather than being admitted to hospital.

Further recognition of our work with young people, was given to staff at Ardenleigh who worked incredibly hard to achieve autism accreditation from the National Autistic Society, which was awarded to our forensic children and adolescent mental health service in January. Our service was the first service of its kind in Britain to achieve this standard of excellence.

The service and its staff had to demonstrate specialist knowledge and understanding of autism and how that knowledge informs all aspects of assessment, care and practice. Younger service users will now benefit from early diagnosis and appropriate treatment to meet their developmental needs.

The Health and Social Care Bill became law in March, and this will pave the way for a wave of changes throughout the NHS, one of which will be introduction of GP commissioners and commissioning groups. Our trust has been working closely with GPs, who will become responsible for purchasing healthcare services for the communities they serve.

Solihull High Street *(Photo courtesy of Stephen Hogan)*

Now there is a greater emphasis on GP care, we need to continue our work with the community to raise awareness of mental health issues, and work closely with GPs to maximise the amount of mental health information available to the public.

As the NHS landscape is set change, trusts are facing difficult choices over how they use their shrinking budgets. In recognition of this our most senior employees have taken a 4.2 per cent pay cut in their salaries this year.

We have worked closely with our commissioners to manage a reduction in funding for our Birmingham Healthy Minds services and, as a result, we have had to change how these services are delivered.

We recognise that working with our commissioners and others in the health economy to deliver real savings for all is the only way to address the challenges ahead.

We believe that we have a significant role to play in supporting the health economy to improve services and make savings outside of traditional mental health services, as demonstrated by RAID.

We have continued to make bold investments to improve our facilities, such as the Tamarind Centre, our new medium secure unit, making us more efficient and improving the care we give to our patients, but we also face the need to quickly realise greater efficiencies.

We acknowledge that we must work harder to further engage with our members. During 2012/13 we aim to grasp the many opportunities there are to work with the public, giving those in seldom heard communities a voice. Over the next year, we will work closely with our 13,080 members, involving them in our work.

Furthermore, we will do our best to improve our service users' lives through our work with other organisations. This means working with people's carers, their families and the wider community to help them lead purposeful lives among people who accept them – breaking down the barriers of stigma, which often accompany mental health problems and lead to social isolation.

As our trust, like much of the NHS, faces some major changes and big decisions over the coming years, we publish our board papers on the trust's website and now invite governors to part of our monthly board meetings, to involve them in discussions on key issues. From 2012/13 our board meetings will be open to the public and members of the media, in a move to improve the organisation's transparency.

On behalf of the trust board, we would like to acknowledge and thank our staff for the hard work, professionalism and dedication they show each and every day in delivering modern, high quality and safe services to our service users, carers and their families.

We would also like to thank our service users, carers, volunteers, community and faith groups, partner organisations and stakeholders who have, and continue to support us with our overall mission to help people get better by getting better together.

Sue Turner, 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, 2011 to March 31, 2012 for the financial year 2011/12.

We provide a comprehensive mental healthcare 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 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 more financial control over the services we provide, 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.

To achieve foundation trust status we had to demonstrate that we are legally constituted, well governed and financially viable.

Our mission

Better together. That's our mission statement, pure and simple. We want to help people get better and create services we are all happy to recommend to others, whether on our own or in partnership with other organisations.

To support this, our vision is that:

• People with common mental health problems are managed effectively within the primary care system;

• People with complex mental health problems are swiftly referred to and managed as appropriate by specialist services in our trust;

• Focused and co-ordinated activities are developed to help improve tolerance and understanding within neighbourhoods and communities, and enhance access to excluded groups;

• Strategic partnerships (subcontracting out, if appropriate) are established with non-statutory sector organisations, community and user-led groups to create a continuum of:

a) appropriate employment, educational, social and leisure opportunities; and

b) appropriate housing (independent and supported).

Our services

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 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, 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.

An award-winning trust

Our trust's reputation for innovative projects continued to grow in 2011/12, with staff winning awards and recognition for their achievements across a range of services.

The combined efforts of our estates and facilities, dietetics, procurement and occupational therapy departments have not only improved the quality and choice of food for patients across our sites, it has become more sustainable by sourcing ingredients from local producers.

This collaborative approach, in light of a spate of stories which highlighted poor nutrition at some NHS hospitals, earned the team two plaudits. The team received first price in the better hospital food category at the Health, Estates and Facilities Management Association Good Practice Awards in April, and best team project award at the Building Better Healthcare Awards in November.

Our forensic child and adolescent mental health service (FCAMHS) became the first service of its kind to receive autism accreditation from the National Autistic Society (NAS) in January.

The specialist service, based at Ardenleigh in Erdington, was awarded this "kitemark" of excellence, which is recognised around the world, in recognition of the special provisions it has made for service users with autism or an autistic spectrum disorder.

Robert Pritchett, director of the NAS Accreditation Scheme, said: "All the staff at Ardenleigh have put in a great amount of effort to achieve this accreditation and we are extremely proud of their achievements. Autism is a lifelong and disabling condition, but with the right support, at the right time, children with autism can flourish".

Our FCAMHS service and it staff had to demonstrate specialist knowledge and understanding of autism and how that would inform all aspects of assessment, care and practice.

Younger service users will now benefit from early diagnosis and appropriate treatment to meet their developmental needs, and will also be provided with information and support around their condition. Staff have received extensive training to expand their knowledge of autism and the range of diagnosis on the autistic spectrum, which has increased their confidence in meeting young people's needs.

In the spotlight

The past financial year has been one of achievement and change for our trust, much of which has made local, national and international headlines.

As a summary, Birmingham and Solihull Mental Health NHS Foundation Trust featured in 23 news articles. Of these 13 were in local newspapers, four were in specialist publications, and six were on websites.

April and May were relatively quiet due to purdah, in the run up to the local council elections. However there was still a mix of positive and negative news stories.

In May, the *Birmingham Mail* ran a story on the trust's use of electro-convulsive therapy (ECT), following a Freedom of Information request, which revealed the number of patients treated with ECT. The tone was negative towards the therapy but neutral towards the trust.

On a more positive note, a feature appeared in The *Birmingham Post* promoting the UK release of *The Insatiable Moon,* which our trust staged a special premiere for in 2010, as it is based on a true story of a man who believes he is the son of God, and looks at mental health issues within a New Zealand community.

In June, *The Voice* wrote a positive story on BSMHFT Dementia Council member Simone Daniel who cares for her grandmother suffering with dementia. The piece referred to our carers' forum and promoted Carers' Week.

However In the following month, *The Voice* ran a prominent piece on the coroner's warning to Kingsley Burrell's family that an inquest into his death may take three years to reach the courts. A detailed feature about the benefits of our RAID service by Professor George Tadros, clinical lead for our RAID, was published on The *Health Service Journal* website.

Media interest in the Kingsley Burrell case continued during October and November, as the BBC and *The Voice* both ran stories. The BBC story mentioned the trust's own inquiry into his death, but the tone towards BSMHFT was neutral.

The loss of a set of keys, which opened every cell at HMP Birmingham in Winson Green, where the trust provides healthcare services, received global coverage in October. The story was featured on abc news, CBS and *Digital Spy* websites in America, appeared in national papers including *The Sun* and *The Mirror*, and attracted local coverage in the *Birmingham Mail*. The negative tone stemmed this incident happening just weeks after the prison became the first in Britain to be transferred to a private sector firm, G4S.

In the run up to World Mental Health Day in October, The *Birmingham Post* promoted the Time To Get Moving event, organised by our trust and Time To Change, in Cannon Hill Park, Edgbaston.

An article appeared in The *Rutland & Stamford Mercury* just before Christmas on the National Lottery awarding £260,000 to the Action Postpartum Psychosis project - led by Dr Jessica Heron, who also leads the perinatal research programme at the Barberry - which helps women with the condition.

Also in December *Healthcare Today* and the *Health Service Journal* both published articles on how our trust has reduced the waiting time for letters by using the BigHand digital diction software and its benefits over analogue tapes.

As the trust began promoting its national RAID conference, both the *Solihull Observer* and the *Sutton Observer* commenting on our pioneering RAID service in January.

Our trust continues to make the news with its awards, new developments and reports this year. *(Photo by Sarah Smith)*

patient care

New services for patients

The Juniper Centre

In June, the Juniper Centre in Moseley was officially opened as the fourth site within the National Centre for Mental Health: Birmingham – which includes the Barberry, Oleaster and Zinnia centres that opened in 2008/9.

Nicholas Parsons, presenter of Radio 4's Just A Minute, officially opened the new £17.7m facility in south Birmingham on June 1 without hesitation, deviation or repetition.

Located on the Moseley Hall Hospital site, the Juniper Centre is a unique development which sits next to existing physical health services for older adults, provided by Birmingham Community Healthcare NHS Trust.

Lord Mayor of Birmingham, Councillor Anita Ward, joined Nicholas at the event, where they met some of our service users.

Nicholas, who cracked some jokes about dementia during his speech, was "truly impressed" by what he saw during his visit, which included meeting patients on one of the new wards.

He added: "We read about areas where the NHS is not coming up to scratch but this is one area which is much more than up to scratch, and you should all be very proud of that.

"As you get older you do get more fragile in your mental health, as well as physically. Society needs people, like the staff here at the Juniper Centre, to give elderly folk the quality of life they deserve as they've earned it, they've worked hard and they've a right to proper care. This is something I'm very passionate about."

The 54-bed hospital is a specialist centre which brings together stroke services, rehabilitation and diagnostic facilities for managing physical and mental health services for older people on the same site.

Patient facilities include therapy rooms, large and airy single en-suite rooms, as well as an internal courtyard gardens and planting of new trees and shrubs around the site.

Alcohol treatment service for Solihull

Solihull Integrated Addictions Services (SIAS) launched a new, comprehensive alcohol service, which provides access to a team of specialists through a single point of contact, this year.

The alcohol treatment service was officially opened by the Mayor of Solihull, Councillor Ian Courts at Solihull Library and Arts Complex on May 20.

SIAS is a successful partnership between our trust's award-winning substance misuse service, based at The Bridge in Chelmsley Wood, with charities Welcome, Aquarius, Str8 Up and the government's Drug Intervention Programme.

The new service provides a single point of contact, for all GP enquiries and referrals, to a multidisciplinary team including alcohol workers, doctors and nurses, as well as support workers to help drinkers with issues around benefits, employment and housing.

Service users may also be referred onto a specialist drug and alcohol liaison team, based at Solihull Hospital, a detoxification service, or a drop-in service at Aquarius's base in Solihull.

Funded by Solihull Primary Care Trust, the alcohol treatment service will provide drinkers with a range of treatment options delivered closer to their homes, in community based settings, as well as support for their families and friends.

Changes to our services

Given the challenging environment we are now operating in, and the need to make savings, we have had to make, changes to our services to ensure our financial position remains stable and also to support our commissioners.

We have worked closely with our staff, service users and commissioners to identify how we can work differently to ensure the quality of service, while reducing the cost.

Nicholas Parsons, Lord Mayor of Birmingham, Councillor Anita Ward and chairman Peter Marquis at the opening ceremony.

Birmingham Healthy Minds
Funding for this service was reduced by 45 per cent in 2011/12. Given such a significant cut in resources, we have had to look carefully at how to get best value from what we already have.

Demand for the service continues to grow and this has caused some people to have to wait longer than we would want them to before they can access services.

Our clinicians have worked hard to look for different and innovative ways of delivering the service to address this, and we are starting to see the benefits. Despite this, our outcomes show that those people accessing the service do recover.

We have also signed an agreement with Birmingham Mental Health Consortium, which represents a number of third sector providers, to work with us to deliver the service.

Birmingham addictions services
At the beginning of the year, our commissioners indicated that they needed to make savings in alcohol and drug treatment services. From April 2012, funding for these addiction services will be reduced by 25 per cent (£2 million).

Our addictions service rose to this challenge and has created a new, innovative approach to how it delivers treatment to our service users. It focuses on recovery, which is in line with changes in government policy.

Improvements in patient care information

Our trust is committed to listening to patients' experiences and views because they are the people who use our facilities and services.

Last year we launched a new project to look at the process of patient feedback and, more importantly, how this feedback is used to improve our services.

To complement the existing channels which carers and patients use to share their views with the trust, we invested in new technologies – touch screen kiosks, tablet PCs and personal digital assistants – on which they could complete a wide range of surveys.

The real time patient feedback project is not just about gathering the raw data from these surveys but also looking at the whole process of feedback, and how the trust can analyse and act on the information it receives.

Ultimately, the purpose of this pilot project was to report back to service users, staff and carers, to tell them how their experiences and views have helped shape our services.

As part of our commitment to listen and learn from service user and carer input, the patient advice and liaison service (PALS) has undergone changes in this year, joining forces with the trust's complaints team to become more customer focused.

The PALS customer relations team are still based at Ardenleigh, but are now joined by their colleagues from complaints, to ensure questions or cases are handled in a more streamlined manner.

Customer relations: PALS
The patient advice and liaison service (PALS) team continues to provide advice, support and information to service users and carers.

This year we have been working with Building Community Advocacy to provide information to staff, service users and carers regarding the new changes in the benefits they are likely to receive and to provide support and information on debt awareness. Due to the success of these sessions, which were held between September and December 2011, PALS will continue to offer these sessions around the trust during 2012/13.

The PALS team have also started a lot of outreach work with carers groups across Birmingham and Solihull in preparation for the up-coming work in developing a trustwide carers' strategy.

As part of a new strategy towards providing more robust systems for issues raised by users and carers, PALS has now joined forces with the trust complaints department to form a trustwide customer relations service. By joining the two services together we will be able to offer a more efficient and timely resolution to issues either by local resolution or through the formal complaint process.

The complaints team have recently relocated to join PALS at their office on the Ardenleigh site. The customer relations service can be contacted on the PALS Freephone number **0800 953 0045.**

Patient experience and involvement
Regular meetings with local voluntary sector partners and representatives of our service users ensure that we hear about the perception of our patients' experiences. This is supplemented by monthly mystery shopper checks which help us to ensure a consistent standard across our large and diverse trust. Our service users and carers perform these spot checks and their standards are set high.

Our carers tell us their views at regular support groups and they use these groups mainly to share their experiences of caring.

Externally we have carers' forums operating at both Birmingham City Council and Solihull Borough Council. These are vital debates, where we as a trust learn about the impact of a host of services, in supporting carers to care.

We have introduced family and friend open days to try to demystify our secure services, for those people who will be essential supporters of our users when they are able to be discharged. These have become busy social events and allow external voluntary services easy access to both clients and their families.

We have used feedback regarding our website to refresh the pages and make them easier to navigate and read. Weblinks to other organisations such as Birmingham City Council's My Care in Birmingham, Choice and Medication, and MIND have also been enhanced for easy use.

Our Opportunities Yearbook, which lists nearly 300 opportunities for groups, information and support across Birmingham and Solihull, has also been revised. New editions of the yearbook and the Buzz Guide mini telephone directory have been printed, also with improved weblinks and postcodes for satellite navigation.

A new workbook was developed which allows staff to take time learning about the services that provide involvement for users and carers and measure their experience of our trust. We are also introducing more service users and carers to training activities and recruitment to better reflect our diverse client base.

Our PALS team have developed new training briefings about the changes to welfare benefits. This has enabled staff to better understand the difficulties service users face when their benefits are changed or re-assessed. We are encouraging service users to make use of our partnership with Birmingham City Council's welfare rights team. They have helped our service users gain benefits, when they were not aware of their entitlement. They have also been able to

Staff nurse Belette Woldermichael shows a service user how complete a patient feedback questionnaire

assist service users with appeals and guide them to help for housing or debt problems.

Many new services were developed in Birmingham and Solihull during 2011/12. We have worked with new providers such as Creative Support and Stonham home group to ensure a seamless service for our patients and carers.

Where our services have moved to new hub locations we have helped teams to advertise this to ensure service users are familiar with bus routes and changes to groups they may attend.

Real time patient feedback

We learn a great deal from our annual patients' survey, but real time feedback gives us this level of knowledge on a daily and weekly basis.

After an extensive real time patient feedback pilot, the trust made a commitment to invest in this initiative during the next financial year, 2012/13. Real time patient feedback involves using handheld touch-screen devices to gather views and opinions from service users, carers and staff.

These responses then get fed directly into a central database, where they can be accessed by staff instantly. This feedback will then be used to make changes to the service.

From the pilot, the team learnt how best to use handheld devices to gather survey responses, making sure that any lasting investment made in these technologies provides added value to the service user experience and can instigate service improvement work.

Through this project – and the survey results – the trust learnt how to improve survey structure; when, where and how to conduct surveys and how to use the results to inform and make meaningful changes to our services.

Working with staff, volunteers and service users across the trust, the team drew up a number of recommendations on the best way to roll out this initiative across the trust, so many more of our services can benefit. These findings were presented to trust board and the Assembly of Governors, who have fully backed the initiative.

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.

We encourage complaints or concerns to be addressed by relevant front line staff, for example, a ward manager or head of department. However, when this is not possible, the patient advice and liaison service (PALS) can be contacted, who will attempt to assist and provide resolution, if this is not possible then callers will be forwarded 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.

The majority of complaints received by the trust between April 1, 2011 and March 31, 2012 – 233 out of 267 (87 per cent) – were answered within the agreed timescale.

Complaints are reported on within the local clinical governance meetings to ensure that improvements resulting from complaints are implemented and will monitor any actions identified. They also get reported on at the trust's regular clinical governance meetings.

In February 2012, the complaints team relocated to our Ardenleigh site in Erdington, to enable them to work closer with our colleagues in PALS to ensure that there is a central point of access for service users and carer to contact the trust with any concerns or complaints. We now work together under the umbrella of customer relations services, and both PALS and the complaints team can be contacted via one number. Callers will be helped as far as possible during that first contact, or be signposted appropriately. Currently there are a range of access points, including the complaints team.

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

Improvements following staff or patient input

Mystery shoppers

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 allow us to see how others view us. We can then improve our services accurately.

Our mystery shopper programme is now in its fifth year of operation.

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.

From these visits, we offer results of

findings and require that an action plan is developed to improve services.

It has been pleasing to note that some visits have resulted in no actions and indeed, a congratulatory bunch of flowers and personal message from the trust's Chair.

In 2011/12 we have used our mystery shoppers to visit all trust sites, assisting the estates and facilities team with their annual inspections. The rigorous Patient Environment Action Team inspections gain valuable insight by having a mystery shopper on board.

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

This year some improvements as a result of visits include:

- Improved poster boards,
- more staff welcome boards,
- less intrusive alarm buzzer,
- tidier gardens,
- more hand washing notices,
- better publicity about carers groups,
- enhancements to staff dress,
- uniform introduction, and
- improved visiting hours.

In 2012/13 our mystery shoppers planned activities will include telephone surveys and visiting our new hubs.

We are also sharing experience across to acute sites, primary care and the private sector through a new commissioner led mystery shopper service reaching out to care homes, dentists and GPs.

Progress on commissioners' targets

In addition to the national targets, we are also required to report to commissioners 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 we record the accommodation and employment status of our service users and demonstrate that we act on any concerns and provide appropriate support.
- 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 at least 90 per cent of admissions of working age adults are managed via crisis resolution home treatment teams prior to admission.
- Ensuring 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.

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. The number of infections reported has reduced from 84 in 2010/11 to 73 in 2011/12.

The infection prevention and control team (IPCT) have further developed the infection control link worker programme and hand hygiene core training programme to promote infection prevention awareness across wards and community teams. IPCT completed 10 environmental audits across the trust during 2011/12.

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.

In conjunction with estates and facilities staff, the team worked with our PFI partner Amey, on a pilot scheme to ensure that domestic staff work with service users, in cleaning their own bedrooms and areas, to facilitate service user programmes and ensure cleanliness standards meet those set by the trust, NHS policy and guidance, and relevant legislation.

A training pack was introduced for service users and clinical staff. This

Staff nurse Kanwall Naseem, Dee Roach, executive director of quality, improvement and patient experience, Beverley Colstock, health care assistant and Stuart Wix, deputy director of nursing and quality, model the trust's new staff uniforms

consisted of a theory section, which highlights the importance of good infection prevention and control in terms of why we clean, how we clean and what we need to clean. The second part of the training involved practical cleaning demonstrations by the Amey team, in kitchen, bathroom and bedroom areas.

The IPCT have continued to undertake decontamination, environmental and kitchen audits as part of the annual audit programme.

Hand hygiene awareness continues to be a high priority for the IPCT as hand decontamination remains as the most effective way of reducing all avoidable infections. The team's hygiene adviser has worked collaboratively with matrons to develop and initiate quarterly hand hygiene observation audits in inpatient areas.

The introduction of 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.

Strategy for professional nursing 2014

Our strategy for professional nursing sets out our priorities as we progress with drive and enthusiasm to achieve our vision of creating a quality nursing service across all trust areas.

It is a culmination of the work from numerous engagement workshops, focus groups, one to one interviews and feedback provided by nurses, other professionals, service users, carers put together with views of colleagues in other parts of the health economy.

Our strategy has been 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.

And 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.

Throughout the development of our strategy, our nursing workforce was clear that our service users, their carers and their families must be at the heart of what we do.

We agreed that they deserve a nursing service that can demonstrate its quality, and which is delivered by skilled and competent professionals. We launched our strategy at our International Nurses Day celebrations in May. One year on, during the celebrations in 2012, our zones presented displays to illustrate how they are helping to make the strategy a reality.

Learning lessons

Ensuring improvements 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.

Last year we commissioned an independent review of our processes for managing and reviewing serious incidents. This was undertaken by an external team which included a non-executive director from another NHS trust, who led serious incident reviews.

Overall the review highlighted that our trust was developing its arrangements and had taken a number of actions during the past year to improve practice. The review also highlighted opportunities for further improvement.

Feedback from the review was shared at a trustwide workshop and also our trust board. As a result a wide ranging plan was developed to further improve our reviews.

As a result of reviews undertaken of all serious incidents recommendations are made for individual services. We also review these issues across all services to identify areas where learning can take place across the organisation.

A range of issues were highlighted which led to actions to reinforce appropriate practice, in particular these have reflected:

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

Further work has been identified to update trust policies in relation to dual diagnosis and management of service users who do not attend their appointment.

All serious incidents are shared and reviewed with our commissioners who also review the reports of all of our reviews.

Improvements in how we manage risk

More than 12,000 incidents are reported a year across the trust, ensuring that staff can flag up any concerns or identify issues which could impact on patient safety.

In line with national best practice, our trust recognises that by encouraging all staff to report any potential incidents, this encourages a higher awareness of patient safety and supports management action to be taken.

Serious incidents often occur following repeated occurrence of minor incidents or similar situations, therefore reviewing these provides an opportunity for the proactive actions to be taken to prevent serious incidents occurring.

Over the past year the number of incidents reported by staff has increased and the trust is recognised and praised as one of the highest reporters of incidents for all mental health trusts, by the National Patient Safety Agency. More importantly this trend reflects lower risk incidents providing an opportunity to improve patient safety.

During 2011/12 our trust commissioned and implemented the use of an electronic risk management system which enables staff to report incidents electronically through the trust's intranet, Connect.

The newer system is promoting further higher levels of reporting due to its ease of use and will also provide managers with more detailed and timely information to improve our responses.

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 male forensic facility, in Bordesley Green, has really taken shape and is nearing completion.

Following in the tradition of other recent new build sites, such as the Juniper Centre and The Barberry, this 89-bed hospital will be called the Tamarind Centre.

Tamarind is a tree indigenous to India and tropical Africa, which has known therapeutic properties, and spice derived from its fruit is used in many Asian dishes.

This name was chosen as it promotes healing and recovery, which will be at the heart of our new medium secure unit, which is due to open in late 2012.

Inpatient ward names have also followed a similar theme and will be named as follows: Acacia, Hibiscus, Lobelia, Laurel, Mulberry, Myrtle and Sycamore.

This development will create more than 300 jobs ranging from healthcare assistants to clinical psychiatrists, and recruitment began in June. Existing trust staff have also taken part in a preference exercise, which will also be considered during the recruitment process.

The first service users are due to move into the trust's new medium secure unit between December 2012 and January 2013. It is expected to be fully operational by spring 2013.

Our governors got a first glimpse of the site in the spring, when they saw how building work has progressed. They went on a tour of the site and saw where the suites and recreation areas will be.

Peter Tinsley, public governor for Birmingham, said: "This excellent state-of the-art facility will provide a quality service for users, with a strong emphasis on rehabilitation. It will be staffed by people skilled in the care and rehabilitation of this particular group of service users.

"Its security arrangements will benefit both residents and staff and I look forward to the opening of this fine building."

Alan Kenny, director of commercial services and asset management, and Pat Hemmings, one of the trust's governors, visit the site of the new Tamarind Centre, due to open next year

innovations in mental health

Our trust prides itself on blazing the trail forward with new innovations and interventions – and 2011/12 was no exception.

Many of our achievements have been pioneered in partnership with other NHS providers, third sector organisation and private enterprises.

Since it was launched as a pilot scheme at City Hospital in Winson Green in December 2009, our Rapid Assessment, Interface and Discharge service (RAID) has gathered momentum - and a national reputation.

This year was significant in its development, with leading government officials – including the mental health tsar Dr Hugh Griffiths, and the national clinical director for dementia, Professor Alistair Burns – visiting Birmingham to see what the service is all about.

A report into the clinical and financial impact of RAID, by the London School of Economics (LSE) for the NHS Confederation, praised its innovative approach for improving patient outcomes and saving money when it was published in November.

Conservative assumptions on savings, made in the LSE's report, revealed RAID could make savings of £4 for every extra £1 invested in the service.

Understandably with figures like that in the public domain, it attracted a lot of professional and media interest, which culminated in a national conference held at the International Convention Centre in Birmingham in January.

To illustrate how far this ambitious, yet simple, service has come since it was first piloted – RAID is due to be rolled out at four more NHS hospitals in Birmingham and Solihull from April 2012.

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 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 team manager Mike Preece outside City Hospital's A&E department, where the new service is based *(Photo courtesy of Nursing Standard)*

RAID is a great example of how this strategy is working in Birmingham, where by the end of March 2012, four more hospitals – the new Queen Elizabeth, Heartlands, Good Hope and Solihull – were preparing to roll out RAID services.

The extension of this enhanced psychiatric liaison service, which already provides a 24-hour service at City Hospital, marks a change in fortune for RAID, which only last year faced an uncertain future despite winning a Health Service Journal Award for mental health innovation.

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.

Originally RAID was set up as an 18-month pilot scheme, but it was extended in March 2011 after additional funding was secured from local commissioners to plug a £600,000 funding gap.

National interest

Dr Hugh Griffiths, the Government's mental health tsar, praised our innovative RAID service, during a visit to the trust on April 15, 2011.

Dr Griffiths was taken on the patients' journey from arriving in A&E to being assessed and treated by the RAID team, before being discharged.

During the tour, Dr Griffiths saw how our clinicians work in partnership with colleagues at City Hospital, which is run by Sandwell and West Birmingham Hospitals NHS Trust.

Dr Griffiths, who is also a consultant psychiatrist for Northumberland, Tyne and Wear NHS Foundation Trust, said: "The RAID service is pioneering new approaches to mental health care and partnership working across the NHS. This ground-breaking service is clearly at the forefront of mental health innovation, improving patient experience while making significant savings."

This partnership approach has not only resulted in better patient care but has also avoided unnecessary admissions to busy medical wards. RAID has shown it can reduce the length of stay for patients with dementia, to save the equivalent of two medical wards.

Chief executive Sue Turner with Professor Alistair Burns, Chair Sue Davis, Dr George Georgiou and Professor George Tadros at the RAID conference

London School of Economics report

The clinical and financial impact of RAID has received national recognition in a report by the London School of Economics (LSE) for the NHS Confederation, published in November 2011, which praised its innovative approach for improving patient outcomes and saving money.

Conservative assumptions on savings made in the LSE's report, revealed RAID could make savings of £4 for every additional £1 invested.

Previously people could face lengthy waits before being referred onto the relevant service but under RAID, clinicians are able to assess patients within an hour of arriving at A&E or within 24 hours if on a ward. Since April 2010, the service has been available 24 hours a day, seven days a week, at City Hospital.

From April 2012, RAID will initially operate seven days a week between 8am and 8pm, at the Queen Elizabeth, Heartlands and Good Hope Hospitals. The service at Solihull will be initially run between 8am and 8pm weekdays and 8am to 1pm at weekends. This will become a round-the-clock service during 2012/13.

RAID conference

The development came as our trust prepared to stage its inaugural national conference on RAID at the International Convention Centre in Birmingham, to share our experience and expertise.

The one-day event, held on January 27, was attended by more than 200 delegates from as far afield as Southampton, Plymouth and Cumbria.

Conference delegates learnt more about RAID, what is behind its high profile success and heard from speakers including Professor Tadros, clinical director for RAID, Peter Spilsbury, director of commissioning development, Birmingham and Solihull Cluster and Paul Kingston from Staffordshire University.

Professor Alistair Burns, national clinical director for dementia, delivered the conference key note speech, during which he spoke about the importance of early diagnosis and intervention in primary care, dementia in general hospitals and care homes and the importance of reducing the use of anti-psychotic medication.

Research and innovation

Enhanced assessment service pilot

Following in the footsteps of RAID is the enhanced assessment service (EAS), which was launched at Nightingale House in November.

EAS provides a seamless, integrated pathway for patients between acute hospitals and specialist rehabilitation services.

Between November and March, staff received more than 60 referrals into the new streamlined service, which ensures service users and their carers receive the best possible interventions and information to help inform the patient's future care.

The time between referral to triage is now one and a half days, and between triage and admission it is less than two and a half days.

The EAS community team has made a major impact, working closely with acute wards, liaison specialist nurses, RAID teams, families, carers and support services in the community over the past five months.

The pilot scheme has been so successful it will now run until September 2012.

Dr Jonathan Mayo added: "It is to the commissioners' enormous credit that, in this difficult economic climate, they recognised the gap between what acute trusts and BSMHFT can offer people with dementia and challenging behaviour."

Staff will continue to develop links with all involved in the care pathways supporting older people with dementia in their communities.

Huntington's trial

Patients living with Huntington's disease are taking part in a pioneering UK drug trial, in several cities including Birmingham, which may offer new hope to those living with the condition.

Experts in neuropsychiatry at the Barberry in Edgbaston, began tests to establish patients' suitability to participate in the first trial of selisistat in the UK in November.

Huntington's disease is a hereditary brain disorder which is usually developed in adulthood between the ages of 30 and 50 and can affect a person's emotions, memory and movement. These are essentially caused by the presence of damaged or bad proteins in their nerve cells, which the body cannot process and discard.

Existing drug therapies can treat some the symptoms but selisistat is the first drug designed to help the patient's body break down these bad proteins so they can be disposed of more easily.

This ground-breaking trial, which is part of an international trial led by Italian pharmaceutical firm Siena Biotech, aimed to test up to 15 patients in Birmingham during its first three month phase. The national trial will involve 50 patients in total.

Dr Hugh Rickards, consultant in neuropsychiatry with our trust, said: "This is a ground-breaking trial in the sense that we are testing a drug which may alter the underlying mechanism of Huntington's disease.

"We are really happy to be offering our patients the chance to participate. This is at a very early stage but we are at the start of a new era of treatments for this disorder. It is also a great credit to the hard work of a number of people at BSMHFT that we are the first to get started with this trial in the UK."

During the three month period participants were given either selisistat or a placebo, and they were monitored closely to check the effect the drug has on the body's systems.

If the UK trial is successful, it will pave the way for a larger trial examining the direct effects of the drug on the symptoms and the course of Huntington's disease.

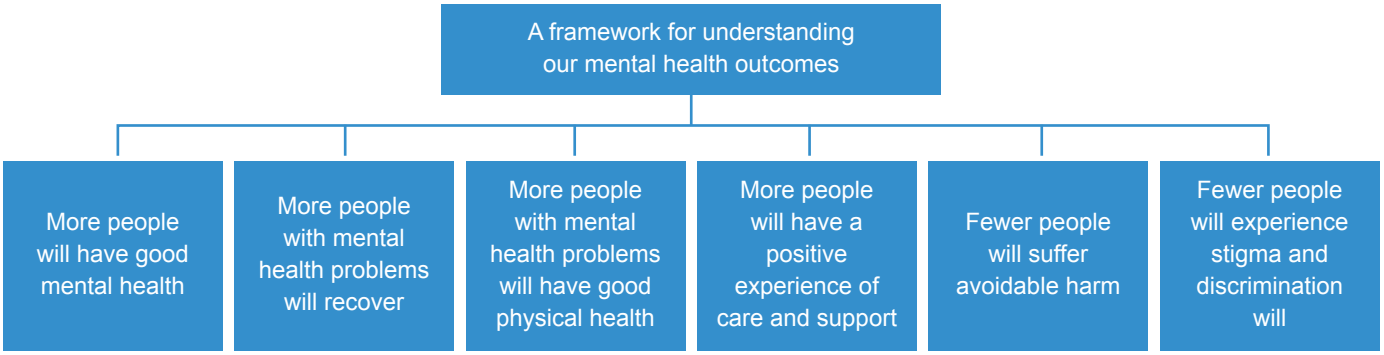
Outcomes

The outcomes that we achieve are very important to us as a provider of mental health care. It is important that we understand whether we are following all guidelines, policies and processes as we should be but it is equally important to know if we are achieving good outcomes for our service users and carers as a result.

This year we have started to put renewed emphasis on how we understand, measure and report our outcomes. We have chosen to use the national mental health strategy and the associated six key outcome objectives as a framework to enable us to do this.

Dr Hugh Rickards talking to Linda, the first patient to be screened for the selisistat drug trial in the UK

Figure 1: Framework of outcome objectives



This year we have been producing a baseline of our mental health outcomes including, what our objectives are in relation to the six key areas above, what measures we are using or will use to adequately capture our outcomes and progress to date. This work tells us that:

- We have a lot of information which we routinely capture in relation to our mental health outcomes.
- We need to do more work to better capture our outcomes in the areas of wellbeing and stigma and discrimination.
- We are capturing information in relation to reducing avoidable harm in our quality accounts,
- We have improved our mechanisms by which to capture patient experience outcomes, that is our real time feedback devices, meaning that in future we will be able to more confidently report these.
- In relation to our recovery outcomes the latest data received from National Mental Health Minimum Data Set tells us that our IAPT recovery rates are improving and are significantly above the national average (43 per cent) and expected recovery rate (50 per cent). In addition the numbers of people on CPA employment is similar to that seen within other large mental health trusts with similar levels of morbidity.

Figure 2: Recovery rate: Number of people not at caseness at their last session

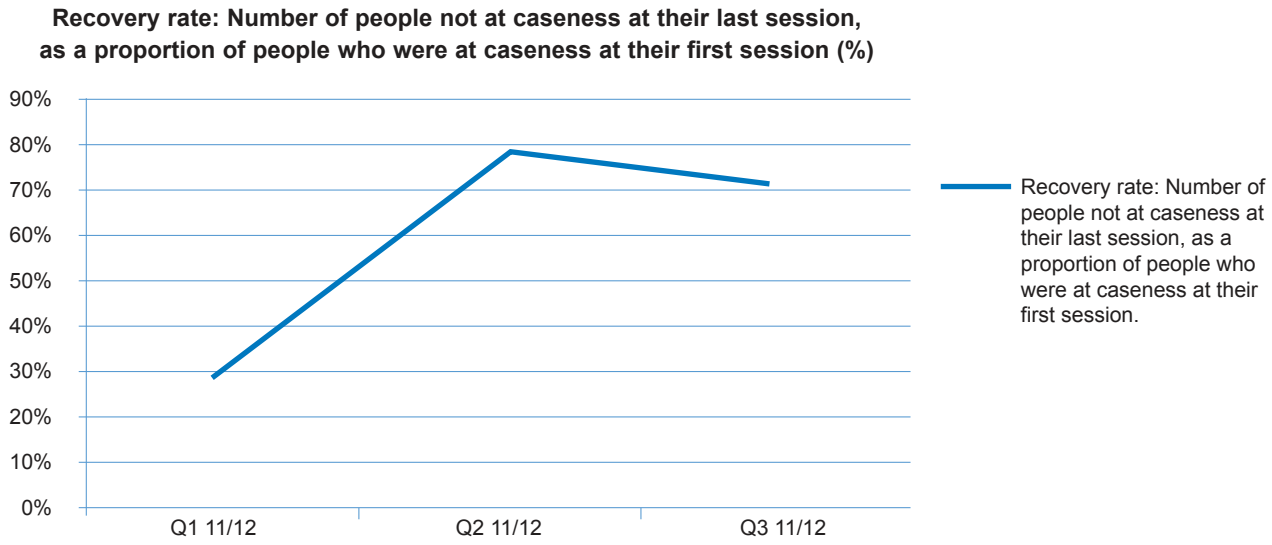


Figure 3: Quarter 2 in 2011/12 – Percentage on Care Programme Approach (CPA) in employment

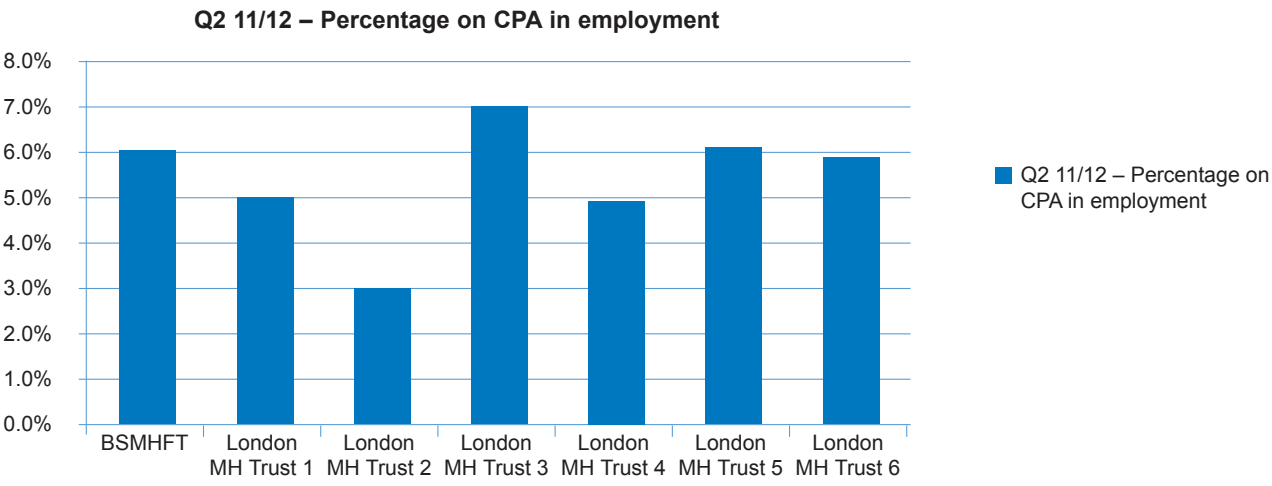


Table 1: Clinical tools used by services to capture clinical outcomes

Service	Tools in use include:
Adult CMHTs	General: Health of the Nation Outcome Scale (HoNOS), Clinical Outcomes in Routine Evaluation (CORE). Disorder specific: Impact Events Scale (PTSD), Becks Depression Inventory (depression), Becks Anxiety Inventory (anxiety), Becks Hopelessness Scale, Personal beliefs about Illness Questionnaire-revised (psychosis), Beliefs about Voices Questionnaire-revised (psychosis), Choice of outcome in CBT for Psychoses (psychosis), Rosenberg Self Esteem Scale (self-esteem), Fear of Recurrence scale (psychosis), Yale-Brown Obsessive Compulsive Scale and Obsessive Compulsive Inventory- revised (OCD)
Adult acute	HoNOS
Adult non-acute	HoNOS, Challenging behaviour checklist, engagement scale, resettlement scale, recovery star
Early intervention service	HoNOS, duration of untreated psychosis
Addictions	**General addictions services:** Treatment Outcomes Profile (TOPS), (client assessment of self at intake (CESI), client evaluation of self and treatment (CEST). **COMPASS (dual diagnosis service):** Audit, beliefs of alcohol or drug use, importance and confidence assessment, readiness to change, severity of dependence, substance abuse treatment scale, clinical alcohol use scale, clinical drug use.
Birmingham Healthy Minds	Generalised Anxiety Disorder Scale (GAD-7), Patient Health Questionnaire (PHQ-9)
Specialist services	HoNOS and specialty specific - eg mother and baby service use-Hospital Anxiety and Depression Scale (HADS), Infant Characteristics questionnaire (ICQ-6), Postpartum bonding Instrument (PBI), Padua Inventory Washington State University Revision (PI-WSUR), Maternal Antenatal Emotional Attachment Scale (MAES).
Older people services	HoNOS, Control, Autonomy, Self-realisation, Pleasure (CASP-19) and Hospital Anxiety and Depression Scale (HADS)

Out of all our clinical outcome measures, CORE is the most established and is used with service users receiving psychological services in community mental health teams (CMHTs) and specialist psychotherapy services.

Our most recent annual report for CMHTs, produced in July 2011, shows that we achieve reliable and clinical improvement/reliable only improvement for 69 per cent of service users in post-therapy outcome measures.

In addition we have lower percentages of service users where there is no change or maintained post-therapy outcome measure scores.

Table 2: Improvements in post-therapy outcomes

	Average trust post-therapy measure improvements	Benchmark: Secondary care (Lucock et al 2003)
Reliable and clinical improvement/reliable improvement only	69%	58%
No change/maintained	27%	38%
Deterioration	4%	4%

stakeholder relations

Communicating 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 trust and openness, 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 for 2012-15.

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.

In 2011 the magazine went from being a bi-monthly magazine to a quarterly publication to increase pagination, but at the same time reducing publishing costs.

Copies of each issue are available at all trust sites, and personal copies are posted to every trust member. Electronic copies are also available via email or can be downloaded from the trust's website.

BSMHFT website

Our website was redesigned to make it easier for visitors to navigate and interact with the site's content.

The website www.bsmhft.nhs.uk also 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.

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, these 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 13,080 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 2011/12.

Recruitment activities to date have included:

- Attending meetings with partner organisations;
- participating in voluntary sector events;
- face to face recruitment in local shopping centres;
- publicity on the trust website and intranet;
- 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, 2012 the membership for each constituency was as follows:

Public: 7,326
Patient (including carer): 1,418
Staff: 4,336
Total: 13,080

We are working with governors to develop 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 on 0121 301 1274, or by writing to the governor c/o: Governor liaison office, BSMHFT, 50 Summer Hill Road, Birmingham, B1 3RB.

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.

Birmingham Reducing Gang Violence (BRGV)

The Birmingham Reducing Gang Violence strategy is a culmination of intensive work which began in January 2003, following the New Year's Eve shootings which claimed the lives of Charlene Ellis and Letisha Shakespeare in Aston.

This strategy is reviewed annually to ensure work remains focused and committed to making Birmingham safer.

It sets out how BRGV, in conjunction with its partners, will address the challenges associated with gangs which, while not unique to Birmingham, are complex criminal justice issues, which are often linked to mental health and wellbeing issues.

In 2011/12 our trust joined BRGV as the NHS/mental health representative, which recognises it is not only important to tackle outward facing issues linked to gang culture but also underlying traumatic health issues that have a significant impact on vulnerable individuals and the wider community.

There are three strands:

BRGV Executive: A strategic partnership group led by the Association of Chief Police Officers and includes senior representatives from partner agencies, who meet quarterly.

BRGV Tactical: This group comprises of operational police leads and key stakeholders. They meet monthly and their agenda is set by the executive group.

BRGV Operational: This group's role is to ensure that all duties, identified through threat and risk assessment have been discharged around offenders, victims and locations. This group report to the tactical group.

BSMHFT are represented by the director of community engagement, who is a member of BRGV executive, and the community engagement manager, who sits on the tactical group.

Work began this year on developing wrap-around services with various

community partners to ensure support is available to those who have been under the care of forensic services, in particular those at Reaside, as they return their own homes and communities.

This collaborative approach is helping key partner agencies to scope and explore the delivery of improved care pathways in secure and complex care. This will work will also support and further inform service users, cares, community and staff in managing the challenges of anti-stigma in mental health and criminal justice.

World Mental Health Day

On October 10, 2011, World Mental Health Day, we screened a documentary *Lunatic* – which aims to remove the stigma associated with mental health – that took clips from *The Insatiable Moon* to challenge stigma associated in particular with madness, after the documentary there was a question and answer session.

Some of the residents at Highgate also got involved with the community at a stand-up comedy workshop.

The event, organised by Women and Theatre in Moseley and hosted by Janice Connolly, culminated in a performance at Stanhope Hall Community Centre. The audience and participants both enjoyed an evening of laughs and mental health awareness.

Volunteering and anti-stigma champions

The trust continues to receive many enquiries about volunteering opportunities.

We work in partnership with many organisations that have volunteers who can bring a fresh and exciting approach to the activities that service users can participate in.

Among the organisations who provide opportunities for our volunteers are Community Vibe, Full Potential Arts and Hearth.

Community Vibe's artistic director, Rachel Green, works closely with many volunteers in order to undertake many projects and pieces of work with the trust. Full Potential Arts use volunteers to provide art-based activities that service users can partake in. Hearth works with volunteers for Reading for Wellbeing.

The trust continues to recruit anti-stigma champions, on a voluntary basis, to support the community engagement team at a wide range of awareness-raising events.

These individuals make a valuable contribution in a number of areas and we thank them for all their commitment and involvement in the work that we do.

However, volunteers do not undertake the same duties as staff but they can make a real difference to the services our trust provides.

Future opportunities are advertised on the trust's website – www.bsmhft.nhs.uk – and for more information email volunteering@bsmhft.nhs.uk

Partnerships: Working together

Birmingham Children's Hospital NHS Foundation Trust

Our trust joined forces with Birmingham Children's Hospital to improve mental health services for young people across the city.

Both trusts signed a partnership agreement in January as a commitment to strengthen services to improve the care received by children, young people and their families.

Sue Turner, chief executive of our trust, and Sarah-Jane Marsh, chief executive of Birmingham Children's Hospital, met at the city centre hospital to sign the joint pledge.

Both organisations have been working closely to provide an intensive home support service to young people with the most enduring and serious mental health problems.

This work has already resulted in more children across the city getting the care they need closer to home, rather than being admitted to hospital.

Chief executive Sue Turner with Sarah-Jane Marsh, chief executive of Birmingham Children's Hospital at the signing

Together, both trusts aim to create an improved eating disorders service, develop and strengthen intensive home support service, improve access to high dependency and intensive care for patients who need the most acute care, and provide an integrated care pathway for 12 to 25-year-olds.

More than 75 per cent of enduring mental health issues occur before the age of 25, with a steep rise from the age of 14.

Both trusts are keen to ensure young people receive the best possible care as close to home as possible, from the right health professional, in the most appropriate environment and without unnecessary transitions between services at critical points in their development.

Lakhvir Rellon, director of community engagement, and Matt Daniels, chief executive of Sound It Out with the signed memorandum of understanding

Birmingham Repertory Theatre / The Hearth Centre

All the world could be a stage for our service users, after our trust signed an agreement with Birmingham Repertory Theatre (The REP) and The Hearth Centre to use drama to promote mental wellbeing.

The three partners signed an agreement in May, through which they will work together to share their skills, expertise and resources to encourage service users to engage in arts-based activities and to help reduce the public stigma around mental health.

The pledges contained within this innovative partnership include:

- Improving access to drama and theatre for service users, carers and staff – including training opportunities and attending performances;
- Showcasing work created by service users, and staging performances within some of the trust's sites;
- Working with theatre students at Birmingham School of Acting to increase their awareness of mental health issues and services; and
- Involving members of The REP's creative and learning teams in projects with service users.

Sound It Out

BSMHFT is also forged a new community partnership with musical organisation Sound It Out.

The social development agency, based in Birmingham, signed a memorandum of understanding with our trust in December, to formally recognise the partnership's shared commitment to provide people with opportunities in music, whether that involves blowing their own trumpets or singing a new song.

Sound It Out was founded 20 years' ago in 1992 and has a long track record for delivering high quality development programmes which often give people with no or limited access to musical education or instruments to work with musicians across the West Midlands.

The organisation provides training and musical opportunities across four areas, in wellbeing, social cohesion, professional development and working with children and young people.

Sound It Out works with vulnerable groups and individuals, to encourage them to explore their creativity and make original music. This can be part of a recovery programme or can help reduce isolation of marginalised cultural groups, and build stronger local communities.

Both partners have pledged to work closely together on developing new programmes, engaging with trust staff to support in the further development of arts in health and wellbeing settings.

non-financial reporting

Our flourishing green space at the Uffculme, in Moseley

Sustainability and climate change

BSMHFT continued to demonstrate its commitment to sustainability, reducing its carbon emissions and minimising its impact on the environment and climate change.

Sustainability forms an integral part of the trust's core business. During 2011/12 our trust won a prestigious catering award which included an integrated focus on sustainability and local fresh produce and minimising wastage.

Our trust continues to demonstrate robust governance for sustainability issues with both director and non-executive director leads, an operational group and the necessary strategies and polices supported by a carbon management plan to enable a sustained, compliant and strategic approach.

This financial year has also seen the start of a significant service redesign and estate rationalisation programme whereby the trust will be ceasing to provide services from a significant number of buildings. The decommissioning of these buildings has followed sustainability principles ensuring that where possible furniture and equipment is re-used within the trust, for example to Creative Support, who provide day care and activities including pottery and music therapy, or is used to help support local community initiatives like Youthspace here in Birmingham.

Managing energy as a finite resource, minimising and mitigating energy wastage has had a positive financial impact on the trust. A combination of the energy management demonstrated and competitive utility prices in 2011/12 has enabled the trust to benefit from a non-recurring cost reduction against budget of £390,000.

Principles are continually practiced to promote awareness of the trust's responsibilities and to engage staff, service users and carers. 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 recycling materials from sustainable sources.
- Promoting the need to embed sustainability within the day-to-day business of the trust.

BSMHFT performance analysis: Carbon management

Table 3: Performance analysis: Carbon management 2008/9 to 2011/12

Year	Electricity, gas and oil (tCO_2) - (Taken from properties where actual data is available)	Transport (inc taxi, grey fleet vehicles and fleet vehicles) - (tCO_2)	Waste (tCO_2)	Total (tCO_2)
Baseline year of 2007/08 including waste, energy and transport				12,353 (estimated)
2008/9	10,647	980	175	11,647
2009/10	10,231	938	134	11,303
2010/11	10,852	900	91	11,843
2011/12	10,195	900 (estimate as data not yet available)	90	11,185

As the table demonstrates 2011/12 has seen a six per cent decrease in our CO2 equivalent footprint, a significant achievement.

Furthermore our trust is working nationally on developing A Framework for Carbon Footprinting of Mental Health Services which it is anticipated will also include the carbon footprinting of procurement – an exercise which our trust undertook for the first time in 2010/11.

Carbon reduction commitment (CRC) energy efficiency scheme

BSMHFT has made a declaration and information disclosure on the CRC as required. However we have 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.

Our trust will respond to and work within guidance being developed by Department for Energy and Climate Change regarding revisions to the CRC qualification criteria and trading regulations.

Indeed it is highly likely that we will qualify for the second phase of the CRC post 2012/13.

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 whom we are working with to develop a national pre-acceptance audit tool for hazardous waste.

Table 4: Performance analysis: Waste management 2009/10 to 2011/12

Waste	Non-financial data 2009/10	Non-financial data 2010/11	Non-financial data 2011/12
Total waste arising	1258 tonnes	1229 tonnes	1186 tonnes
Waste sent to landfill	361 tonnes	263 tonnes	249 tonnes
Waste recycled	887 tonnes	958 tonnes	931 tonnes
Percentage of waste recycled	70%	77%	79%
Waste incinerated	10 tonnes	8 tonnes	6 tonnes

Table 5: Expenditure on waste disposal 2009/10 to 2011/12

	2009/10	2010/11	2011/12
Total expenditure on waste disposal	£184,943	£217,678	£217,922

In addition to the above volumes and costs the trust estate rationalisation programme has led to old and tired furniture, that is not suitable for redistribution within BSMHFT or to charitable organisations, being disposed of. Given the nature of the rationalisation process it has not been possible to quantify this in terms of tonnage or waste costs.

It is a positive reflection on what and how we use what we procure that the total waste tonnages have reduced and our recycling percentage has increased to 79 per cent.

The tonnage and cost of our confidential waste has increased this year being largely attributable to the trust estate rationalisation programme and the more intense records management that has had to be adopted by our clinical and service delivery teams.

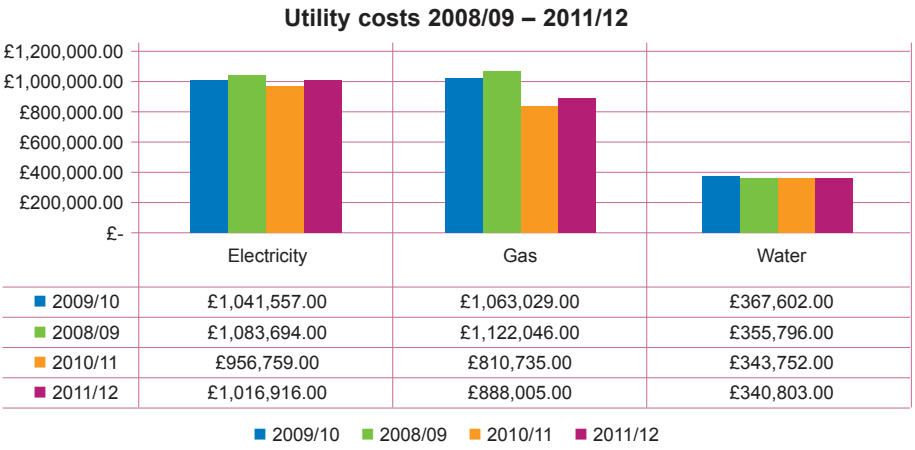
Finite resources: Electricity, gas and water

The table and supporting graphs overleaf demonstrate how:-

- Gas and electric expenditure has been effectively managed throughout 2011/12.In particular it should be noted that:
  – Gas: Utility prices rose on average by 21 per cent in 2011/12 against 2010/11. Actual expenditure rose by only nine per cent.
  – Electricity - Utility prices rose on average by 10 per cent in 2011/12 against 2010/11. Actual expenditure rose by only six per cent.
- Energy consumption decreased in 2011/12, from the previous year by 11 per cent, which is a significant achievement.
- The reduction in energy consumption representing a cost avoidance in 2011/12 against 2010/11 of approximately £200,000.

Please note, on occasions where actual data is either not available or verified, evidence-based estimates have been used.

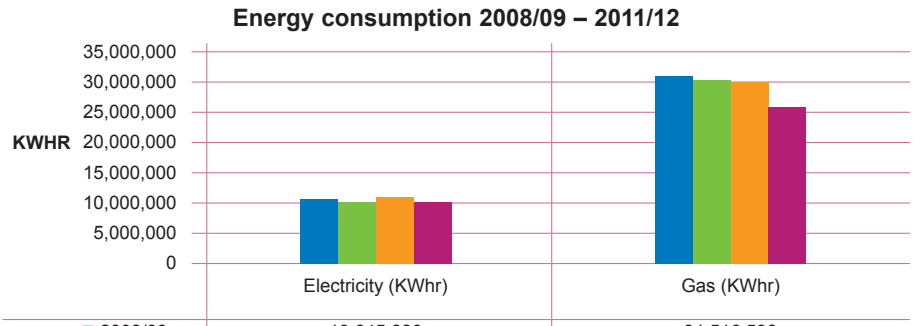
Figure 4: Utility costs 2008/9 to 2011/12



	Electricity	Gas	Water
2009/10	£1,041,557.00	£1,063,029.00	£367,602.00
2008/09	£1,083,694.00	£1,122,046.00	£355,796.00
2010/11	£956,759.00	£810,735.00	£343,752.00
2011/12	£1,016,916.00	£888,005.00	£340,803.00

2009/10 2008/09 2010/11 2011/12

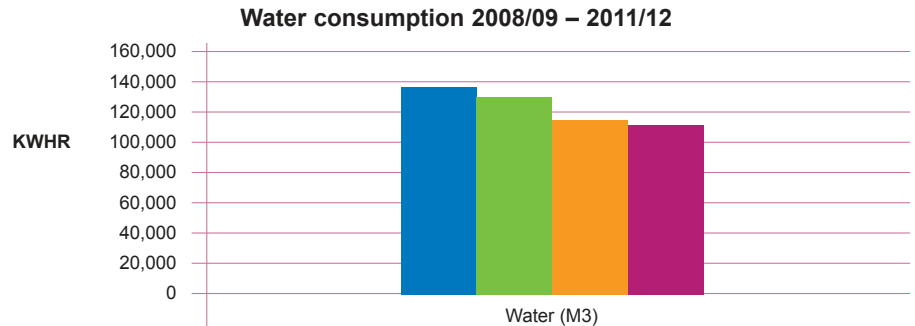
Figure 5: Energy consumption 2008/9 to 2011/12



	Electricity (KWhr)	Gas (KWhr)
2008/09	10,645,686	31,516,593
2009/10	10,276,180	30,601,265
2010/11	10,944,105	30,083,279
2011/12	10,266,405	26,092,710

2009/10 2008/09 2010/11 2011/12

Figure 6: Water consumption 2008/9 to 2011/12



	Water (M3)
2008/09	137,023
2009/10	129,988
2010/11	115,111
2011/12	112,696

2009/10 2008/09 2010/11 2011/12

The positive performance on energy, waste and water in 2011/12 being primarily due to:

- Investment in plant, technology and improvements to facilities;
- the continued drive to minimise energy wastage and promote environmental efficiencies;
- energy and water tariffs / procurement efficiencies; and
- the initial impact of the trust's estate rationalisation programme.

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 (42,896 tCO_2 for 2010/11). This has helped to target key categories of spend for focused attention on buying more sustainably.

BSMHFT has a sustainable procurement action plan in place, which is soon to be developed into a formal policy. This supports the trust's 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. Sustainable product specifications available from the EU Green Procurement website are used in relevant tenders.

Biodiversity

Biodiversity is important to our trust – ensuring where possible that in particular our inpatients have access to green spaces.

The grounds and garden contract highlights our commitment to biodiversity with priorities that include maintaining and improving our green spaces, mulching and composting our waste, allowing green waste to also naturally biodegrade and in turn enrich our grounds.

Priorities and achievements

Our trust, by nature of the national awards it has won since 2009, 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.

Thus building on the achievements made over the last few years our trust needs to:

- Be innovative in the way it continues to drive down energy wastage. Continually developing a range of tools and materials to promote our commitment to sustainability, engaging with staff and service users.
- Invest where business case exists 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.
- Work with our partners to drive down waste, increasing recycling further and seek further financial efficiencies.
- Ensure that the development of the Tamarind Centre medium secure unit encompasses sustainable development principles and designs out wastage as a core component of its development.
- Lead in promoting sustainability in the wider community in collaboration with other organisations from the public, private and voluntary sectors.

As we said last year - we recognise 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.

Regulatory ratings

Table 6: Table of analysis for 2010/11

	Annual Plan 2010/2011	2010/2011 Q1	2010/2011 Q2	2010/2011 Q3	2010/2011 Q4
Financial risk rating	3	4	4	4	4
Governance risk rating	Green	Green	Green	Amber-Green	Amber-Red

Table 7: Table of analysis for 2011/12

	Annual Plan 2011/2012	2011/12 Q1	2011/12 Q2	2011/12 Q3	2011/12 Q4
Financial risk rating	3	3	3	3	3
Governance risk rating	Amber-Red	Amber-Red	Amber-Red	Amber-Red	Amber-Red

Since attaining foundation trust status and for the financial year up to quarter 2, 2010/11, the trust board confirmed a continuing declaration of compliance with the trust's terms of authorisation and a green governance risk rating (GRR) in line with Monitor's Compliance Framework requirements.

Review 2010/11

At the time of submitting the GRR plan for 2010/11, the trust was not aware that it would be subject to a Care Quality Commission (CQC) responsive review and CQC compliance actions during the course of the year, explaining why the trust's planned GRR was not sustained for quarter 3.

The quarter 3 rating of amber-green reflects notification received from the CQC that the trust would be subject to a responsive review regarding the safety of healthcare provision across various locations of the trust.

The actual CQC review was undertaken during quarter 4 with outcomes formally communicated by the CQC to the trust on April 4, 2011. The outcomes of the CQC review related to inspection of three (out of more than 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 Compliance Framework, any foundation trust with a major concern identified by the CQC is amber-red rated, hence application of

this rating for quarter 4 2010/11 and reason for the variance from the planned position. The detail is outlined below.

Review 2011/12

The trust's planned GRR rating submitted to Monitor for 2011/12 was amber-red. This was informed by the known outcomes of the above CQC responsive review and related compliance actions.

Action was taken by the trust to address the concerns identified during quarter 1 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 has confirmed assurance and lifted the related compliance actions.

This approach has resulted in BSMHFT continuing to declare amber-red rating for the subsequent quarter's GRR. To date, the CQC has yet to confirm when this review will be repeated.

Further local assurance of compliance has also been undertaken through an internal audit review and re-assessment of the safeguarding standard using the CQC's audit tool.

During quarter two, 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 and welfare of service users	Outcome 7: Safeguarding people from abuse	Outcome 14: Supporting staff	Outcome 16: Assessing and 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 completed actions to be presented to the trust's clinical governance committee in May 2012.

During quarter 3 (January 2012), the CQC undertook a compliance assessment visit to HMP Birmingham in Winson Green. This identified a moderate concern in relation to the provision of medication while the prison is in a 'shut down' situation over the weekends.

This action is deemed to be outside the trust's direct control, however we are reviewing our arrangements with commissioners and HMP Birmingham to enable the prison to put arrangements in place to address the issue.

The trust's GRR for 2011/12 has 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 will only change once the CQC is able to repeat the assessment and confirm compliance.

Jennifer Meek is one of just eight deaf mental health nurses in the United Kingdom – and the only one employed by our trust

quality report

Part one: Statement on quality by the chief executive

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.

This year's quality account arrives alongside the newly enacted Health and Social Care Act 2012. This Act will lead to wide ranging changes in the way that health care is organised and delivered. Service users will have more choice about how they are treated. Primary care trusts and strategic health authorities will be abolished and replaced by commissioning groups or clusters – made up of GPs, nurses and clinicians – to take on responsibility for buying services for their populations. The Act will enable greater local accountability and strengthen the voice of service users. Factor in the generally poor state of public finances and it is evident that provider organisations such as ours are facing a challenging and uncertain time.

Against this backdrop, BSMHFT has spent much of the last year evolving our approach to quality with the involvement of a wide range of stakeholders – our service users, carers, governors, local teams, commissioners and staff.

Our strategy will be underpinned by our trust's vision:

Better together. That's our vision, pure and simple. We want to help people get better and create a service we are all happy to recommend to others.

And the following eight key principles for quality:

1. **Service user focus:** We will strive to meet the needs of our service users and where possible exceed their expectations providing services with a strong recovery focus.
2. **Leadership:** Our board, managers and lead professionals will all work to create an environment in which people can become fully involved in realising our objectives.
3. **Employee empowerment:** Staff at all levels are the essence of our organisation. The full engagement will enable the best use of the skills and abilities for the benefit of those who use our services.
4. **Process approach:** We will define our key processes and pathways to continuously improve on what we do and to manage our resources efficiently
5. **System approach:** We will work to bring related process into one system. This will make us efficient and effective.
6. **Continual approach:** We know we can do things better – continuous improvement is a permanent objective, however big or small the improvement may be.
7. **Factual approach:** Decisions based on fact are more likely to be correct. We will therefore seek to ensure our teams have the right information when they need it.
8. **Mutually beneficial supplier relationships:** Our trust and those who work with us are interdependent. We will seek opportunities to improve our mutually beneficial relationships in order to provide best value.

BSMHFT is particularly committed to building on our long tradition of putting our service users and carers at the heart of what we do.

As part of our developing quality strategy, we have been refining our business planning processes to ensure that in future years there will be structured engagement of service users, carers and other interested parties across our service zones and programmes to identify improvement opportunities at a local level. This will complement our engagement of service users and carers' in determining our strategic priorities for our annual trust wide quality account.

In terms of monitoring quality we have implemented a quality support visits programme, real time patient feedback and nursing metrics initiatives with the common purpose of putting service users and carers at the centre of evaluating the quality of our services.

In addition, BSMHFT has continued to forge ahead with key developments to enhance the quality of care that we provide. We are currently in the latter phases of implementing RiO - our new electronic care record system. This is being rolled out across the trust and will establish one single central electronic care record for each service user, to which staff can electronically record and view up to date clinical and administrative information.

We have successfully implemented Eclipse for live web-based incident reporting, replacing cumbersome A3 paper reports. These developments will improve the quality and usefulness of information available to our teams to aid their decision making and service improvement.

The Tamarind Centre in Bordesley Green, our third medium secure service centre, is nearing completion and will provide quality care in world class facilities.

We have developed new partnerships with third sector organisations and acute trusts. We have signed an agreement with the Birmingham Children's Hospital under which both partners will work together to develop and improve services for young people across the city.

Our Rapid Assessment, Interface and Discharge (RAID) service initiative has proved so successful that it is now being rolled out across the whole of Birmingham and Solihull.

For our quality account, this year has seen our most extensive programme of engagement to determine our trustwide improvement priorities set out in this quality account. This has included meetings with staff, governors; senior management board members, staff, commissioners/LINks/overview and scrutiny committee (OSC);clinical governance (trust and local) and professional leads.

To maximise opportunities for involvement we set up a survey on the trust's intranet for staff to feedback their thoughts and a survey on our internet homepages for service users, carers and wider public to express their views.

The trust board is firmly committed to ensuring that Birmingham and Solihull Mental Health NHS Foundation Trust continues to find opportunities to strengthen the voice of those who use or have an interest in our services.

The quality accounts highlight our commitment, ambition and determination to deliver the kind of healthcare of which we can be rightly be proud of.

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

Signed: S. D. Turner

May 30, 2012

Sue Turner
Chief executive, Birmingham and Solihull Mental Health NHS Foundation Trust

Part two

2.1 Priorities for improvement 2012/13
The trust launched an extensive consultation process to identify the priorities for new quality indicators for 2012/13. This saw a combination of stakeholder engagement meetings and surveys of both staff and service users /public. A particular consultation event was with the Assembly of Governors. Fuller details of this process can be found in appendix one.

The identified priorities for 2012/13 are as follows:

2.1(a) Safety objective

Table 9: Safety objective priorities for 2012/13

To achieve sustainable improvement in the quality of clinical risk assessments	
Rationale	• Clinical risk assessment is a core component of mental health care and the Care Programme Approach (CPA). As clinicians we are involved in making decisions every day about the needs of our service users and the risks they pose. • As clinicians we strive to improve and defend the greatest quality of life for our service users with the resources we have available, while balancing the security and safety needs of the public, our service users and ourselves. By using an evidence based structured clinical judgement approach, risk screening, assessment and management should ensure as fair a balance as possible in meeting these needs.
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.
Current status	CPA Quality Audit has identified the need for sustained drive in the assessment and management of risk across a number of our community teams. **Nursing metrics** April 2012 findings indicate that across our inpatient services: • 87.1 per cent of service users were risk assessed on admission. • 86.5 per cent have a risk management care plan. • 80 per cent of the risk management plans were reviewed within schedule.
Plans	• Risk assessment and formulation of risk management plans will be a priority item for all appraisals of clinical staff 2012/13, with each appraisal informed by audit findings and thorough case load reviews. • We will establish a multi-professional service improvement team to work with one community team per zone throughout the year to establish systems and process that enable quality CPA. This will be based on a plan, do, can, act (PDCA) model of service improvement. • A fundamental review of policy and guidance and tools to support staff. • E-learning resources will be introduced to address training needs identified. This will be two tiered: (i) National learning resource-based package for care coordinators and (ii) an awareness raising package for staff working within CPA framework that do not care coordinate. • Self-assessment by teams against the CPA quality standards will generate locally owned improvement plans. Progress will be overseen by the clinical quality committee. • Matrons to conduct quarterly CPA quality audits and report, the findings of which will be reported to the clinical quality group. • To extend the quality support visits programme for one year to have specialist CPA quality visits. Teams will consist of assistant clinical directors, lead nurse and a service user or carer representative. Every community team (with the exception of those in the pilot programme) will be visited and objectively assessed against quality standards for CPA and systems/processes that enable attainment. • For local clinical governance teams to monitor and drive the quality of clinical risk assessments in their respective zones and programmes.
Monitoring and reporting	• Trust key performance indicator P17 – with drill down to completeness of risk care plan. • Quarterly quality CPA audit results. • Nursing metrics dashboard: (a) Risk management plan formulated, and (b) risk management plan reviewed.
Leads	• Executive lead: Medical director • Responsible committee: Clinical quality committee

2.1(b) Clinical effectiveness objective

Table 10: Clinical effectiveness objective for 2012/13

To improve quality at each stage of our Care Programme Approach (CPA)	
Rationale	**Birmingham and Solihull Mental Health NHS Foundation Trust annual plan goal** To increase patient and carer involvement in the planning of their care and treatment. The aim is to ensure that stakeholders are engaged with so that improvements to services can be focused on their needs and wishes. **Birmingham and Solihull Mental Health NHS Foundation Trust care management and CPA policy (C01)** • We are committed to providing a holistic, integrated and consistent approach to care planning across all services and with our key healthcare partners (ie social care, primary care and other secondary health care providers). • We recognise the need to work collaboratively and to maximise the involvement of the service user and carers through clear communication and engagement. • We need to ensure that the service user's needs are regularly reviewed and their care plan updated. • We need to ensure clear accountability for care planning with a single person who has overall responsibility for care co-ordination. **Birmingham and Solihull Mental Health NHS Foundation Trust strategy for professional nursing 2014** • Care plans are available in a range of formats to suit the needs of the service user. • We have systems in place to ensure that we provide quality care plans, including service user involvement and expected outcomes.
Aims	• To determine best practice principles for structuring clinical services in order to enable comprehensive attainment of the CPA. We will particularly focus on community mental health services. • To compare quality audit with baseline at end of quarters 1, 2, 3 and,4 of action plan to demonstrate progress. • To achieve a green rating for trust key performance indicator P17 (integrated care record completeness).
Current status	**Trust key performance indicators (KPIs)** • C25 - CPA: People on CPA reviewed in last six months 85.1 per cent (green) • C28 - CPA: People on CPA reviewed in last 12 months 63 per cent (green) • P17 - ICR completeness 71 per cent (red) **Quality CPA Audit** • Early findings have demonstrated that significant improvements are required is some trust services in terms of establishing a systematic approach to the use of CPA and ensuring compliance with Birmingham and Solihull Mental Health NHS Foundation Trust CPA and care management policy. • Examples found in some teams include lack of formalised risk assessments, inadequate risk management planning, inconsistent transition and transfer arrangements and significant delays in updating care plans.

2.1(b) Clinical effectiveness objective – continued

Table 10: Clinical effectiveness objective for 2012/13

To improve quality at each stage of our Care Programme Approach (CPA)	
Plans	• CPA quality will be a priority item for all appraisals of clinical staff 2012/13, with each appraisal informed by audit findings and thorough case load reviews. • We will establish a multi-professional service improvement team to work with one community team per zone throughout the year to establish systems and process that enable quality CPA. This will be based on a plan, do, can, act (PDCA) model of service improvement. • This will generate a blue print for how all teams will operate to achieve best clinical outcomes underpinned by quality CPA. • A fundamental review of policy and guidance. • E-learning resources will be introduced to address training needs identified. This will be two tiered: (i) National learning resource-based package for care coordinators, and (ii) an awareness raising package for staff working within CPA framework that do not care coordinate. • Self-assessment by teams against the CPA quality standards will generate locally owned improvement plans. Progress will be overseen by the clinical quality committee. • Matrons to conduct quarterly CPA quality audits and report, the findings of which will be reported to the clinical quality group. • To extend the quality support visits programme for one year to have specialist CPA quality visits. Teams will consist of assistant clinical directors, lead nurse and a service user or carer representative. Every community team (with the exception of those in the pilot programme) will be visited and objectively assessed against quality standards for CPA and systems/processes that enable attainment.
Monitoring and reporting	**Who** • Executive sponsor: Medical director • Responsible committee for monitoring outcomes: Clinical quality committee **What** • Trust key performance indicators C25, C28 and P17 • CPA indicators: – Percentage completion of H&SC assessments for people on CPA – Time taken to allocate a care coordinator • Quality CPA audit: Administered quarterly organised by lead nurses/matrons **When** • Quarterly report to clinical quality committee (July 2012, Oct 2012, January 2013 and May 2013)
Leads	• Executive lead: Medical director • Responsible committee: Clinical quality committee

2.1(c) Patient experience objective

Table 11: Patient experience objective for 2012/13

To improve engagement of service users in care planning

Rationale

Care planning centres on individual needs and choices. The focus is on promoting service user choice and control and supports the better management of risk. The care plan should be owned by the individual service user and be based on relevant and timely information, reflecting joined up working between the service user, their carers and families and professional staff.
Care planning promotes self-management for some or all aspects of health and enhances the therapeutic alliance through shared decision making. Considerable evidence demonstrates the following outcomes:

- Greater satisfaction and sense of control,
- greater confidence in the health care system,
- reduction in inpatient stays,
- reduction in errors and untoward incidents,
- better quality of life, and
- better clinical outcomes.

Birmingham and Solihull Mental Health NHS Foundation Trust care management and CPA policy (C01): We support the concept of recovery, recognising and promoting the service user's strengths and social inclusion.

Birmingham and Solihull Mental Health NHS Foundation Trust strategy for professional nursing 2014: (i) Care plans are available in a range of formats to suit the needs of the service user (ii) We have systems in place to ensure that we provide quality care plans, including service user involvement and expected outcomes.

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.

Current status

Trust indicators
The figures below represent latest care plan for all current service users on CPA, as of April 19, 2012. Percentage reflects recorded entries. Please note that these are the figures for service users whose records are on ePex. A number of services have already switched over to RiO system.

Division	Service users with a care plan	Service users involved in care plan	Service users signed care plan
Specialist and complex care	28%	21%	9%
Adults of working age	66%	54%	36%
Youth, addictions and			
Birmingham Healthy Minds	7%	7%	0%

2.1(c) Patient experience objective – continued

Table 11: Patient experience objective for 2012/13

To improve engagement of service users in care planning	
Plans	• Patient engagement in care planning and decision making will be a priority item for all appraisals of clinical staff 2012/13, with each appraisal informed by audit findings and thorough practice reviews. • All local clinical governance committees and clinical zone business meetings will be required to have a dedicated slot to consider and improve service user engagement in their area. A particular focus for this year will be engagement in care planning. • Self-assessment by teams on the vehicles they use to gather, consider and act on service user and carer feedback will generate locally owned improvement plans. Progress will be overseen by the local clinical quality committee. • Quality support visits will look for evidence of how service users are engaged with their care and the running of their care environment. • We will fully implement the service initiative initiation document to ensure that service users and carers are properly consulted on all developments impacting on the service they receive. • We will review and improve the range of formats in which care plans are provided for service users in order to improve their user friendliness. • We will establish a steering group to drive the routine creation and use of advance directives. Each local clinical governance committee will provide a representative • We will rework our patient experience group to ensure it robustly monitors services, developments from the perspective of maximising service user engagement. It will provide strategic support and guidance and hold teams and key personnel to account for this perspective.
Monitoring and reporting	**Who** • Executive sponsor: Executive director for quality, improvement and patient experience • Responsible committee: Patient experience committee • Programme lead: Associate director patient involvement **What** • **Trust indicators (RiO based)** Percentage of service users with a care plan Percentage of service users involved in care plan Percentage of service users who signed their care plan (or valid reason for not signing) • Percentage of service users with a recorded advanced statement/directive • **Nursing metrics** Have you been offered a copy of your care plan? **When** • Quarterly report to patient experience committee (July 2012, Oct 2012, January 2013 and May 2013)
Leads	• Executive sponsor: Executive director for quality, improvement and patient experience • Programme lead: Associate director patient involvement • Local clinical governance committees and business forums • Steering group: Advance statements (directives)

Priorities for improvement during 2011/12: Update

These are the priorities we set last year in our quality report and how we have made progress during the year:

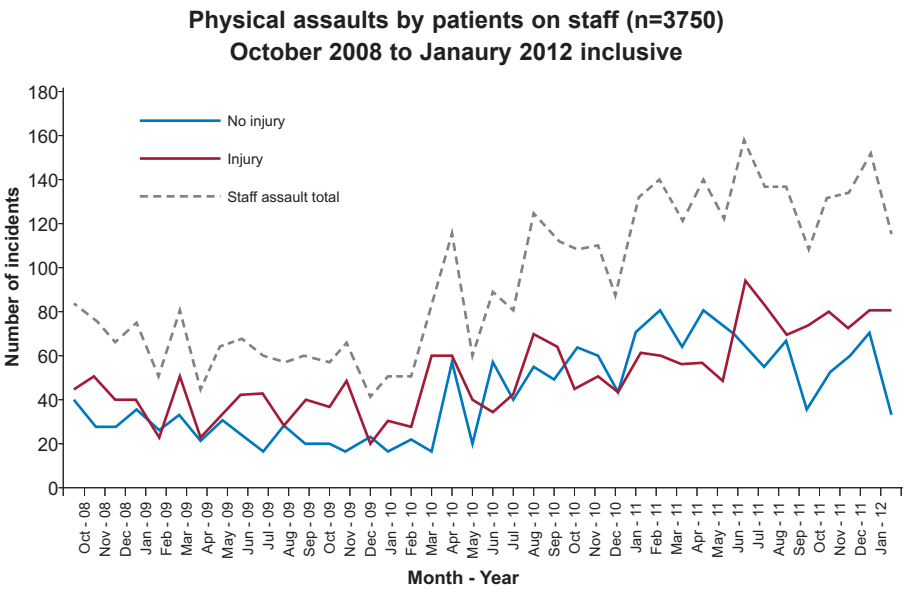
Table 12: Priorities for improvement during 2011/12

	Priority	Aim	Update	Verdict
Safety	To reduce the number and severity of recurring assaults caused by individual patients	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	• Implemented a new web based incident reporting system for better data capture and analysis • Agreed a procedure for managing repeated assaults by single patients • Arranged to trial the procedure in one of our zones, to ensure it is fit for use and that it will provide positive outcomes	Further work to be done in 2012/13
Clinical effectiveness	To improve reporting of physical health assessments within user records	To strengthen arrangements for ensuring service users have received appropriate physical health assessments across all services	• Issued guidance to clinical staff • Provided resource folders to all clinical service areas • Embedded physical health assessments in our nursing metrics programme • Conducted a baseline audit of how well physical health assessments are being completed across community services	√ Further work planned for 2012/13
Patient experience	To improve patient satisfaction in relation to care plan and overall levels of care	To introduce electronic real time feedback mechanisms to drive demonstrable improvements to perceived quality of service by service users	• Improved score for overall satisfaction in patient survey • Carried out a pilot of the real time patient feedback. • Included a carers survey into the real-time pilot • Establishing timescales for further rollout.	√ Further work planned for 2012/13

2.2(a) Safety:
To reduce the number and severity of recurring assaults caused by individual patients

How we had done in previous years:

Figure 7: Physical assaults by patients on staff – October 2008 to January 2012



- As indicated in the graph above, though our reporting of assaults against staff has steadily increased over recent years, the incidence of assaults resulting in injury to our staff has generally remained about the same.
- Significant and award winning work had been undertaken in our child and adolescent mental health forensic services to reduce the incidence and impact of assaults on staff by service users. This had led to a significant reduction overall in 2010/11 as indicated in the table below.

Table 13: Assaults on staff 2009/10 and 2010/11

	2009/10	2010/11
Total assaults on staff	671	1279
Total assaults on staff leading to injury	427	627
Percentage of total assaults that resulted in injury to staff	64%	49%

We aimed:
- 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.

We planned:
- To produce a good practice guide, to build on previous work in our forensic child and adolescent mental health services.

So far we have:

✓ Implemented a new risk management information system which will enable improved data recording and analysis.

✓ Agreed a procedure for managing repeated assaults by single patients, developed from the work in our youth service.

✓ Arranged to trial the procedure in one of our zones, to ensure it is fit for use and that it will provide positive outcomes.

Table 14: Performance against patient-related indicators January 2012 to April 2012.

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% ↑

Further update

It had been our intention to implement a new risk management system early in 2011/12.

We had hoped that this new system would enable closer and more detailed monitoring of recurring incidents and in particular that it would allow us to identify that small number of service users who are responsible for significant numbers of assaults on others and so focus our interventions and support.

Unfortunately, the procurement process for this system took longer than originally envisaged, although the functionality is now in place. We have only recently begun to fully use the new risk management system.

Therefore we still have much to do and will continue working on this priority in 2012/13. Our approach will be two pronged:
- Pilot and implementation of a process for managing repeat assaults on staff in one area
- Monthly centralised monitoring of incidents to direct focused support to teams for the management of service users who are responsible for multiple assaults.

2.2(b) Clinical effectiveness
To improve reporting of physical health assessments within service user records

How we had done in previous years:
The level of physical health assessments of service users had improved over previous years however some inconsistency remained, particularly in our community teams.
We aimed:
- To strengthen arrangements for ensuring service users have received appropriate physical health assessments across all services.

We planned:
- To strengthen and reinforce the guidance we had already developed.
- Monitor completeness of physical health assessments.
- Work with primary care services for sharing of information about physical health monitoring.

So far we have:
✓ Created and issued the AGE of Physical Health document to provide at a glance guidance to clinical staff.
✓ Issued resource folders to all clinical service areas, providing detailed information about physical health, trust tools and access to services. This includes information about the framework for the management of health anomalies.
✓ Conducted a baseline audit of how well physical health assessments are being completed.
✓ Our nursing metrics programme has demonstrated a sustained improvement trend in recording of physical health assessments across all inpatient services in the between January and April 2012.

Our baseline audit of physical health monitoring completed in April 2012, indicates a wider variation in the standard of physical health monitoring across our community teams. Examples of good practice were found at the early intervention service at Solihull, Yewcroft community mental health team (CMHT), Adams Hill assertive outreach team, and Handsworth home treatment, as well as areas for improvement (Ten Acres CMHT, Sparkhill home treatment, Solihull CMHT and early intervention in south). A breakdown of results by type of team is shown below:

Figure 8: Results of physical health audits by assertive outreach teams

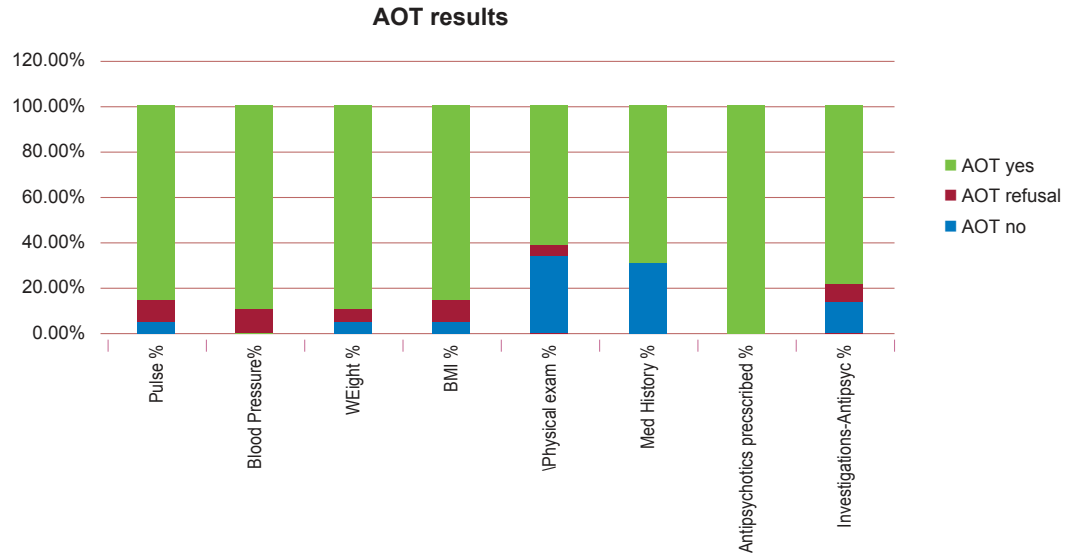


Figure 9: Results of physical health audits by home treatment teams

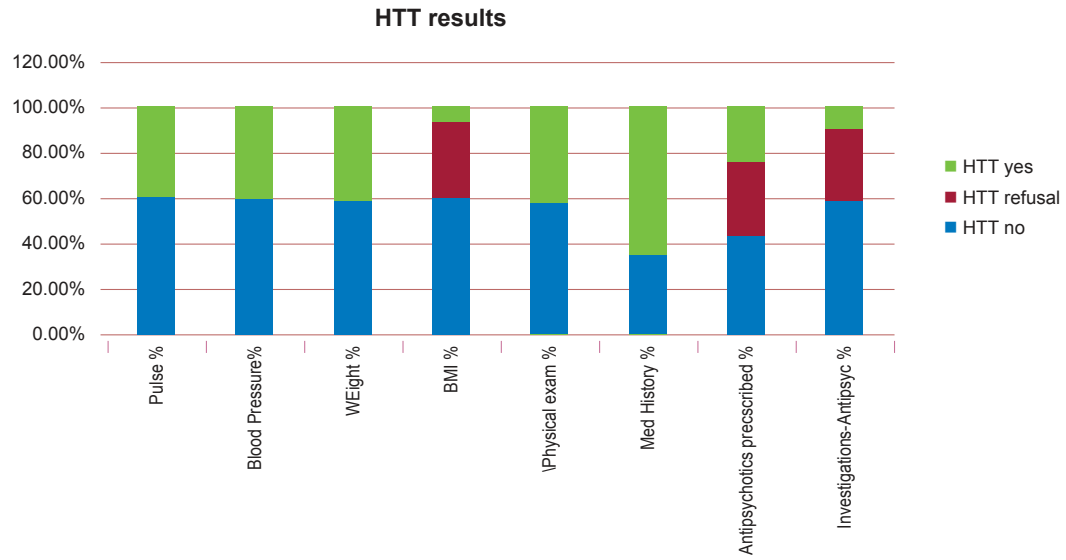


Figure 10: Results of physical health audits by early intervention services

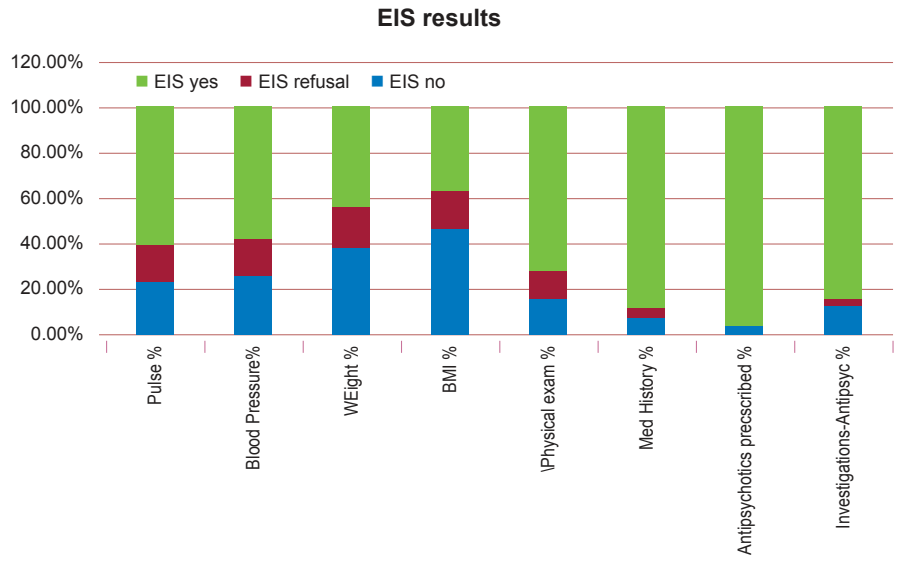
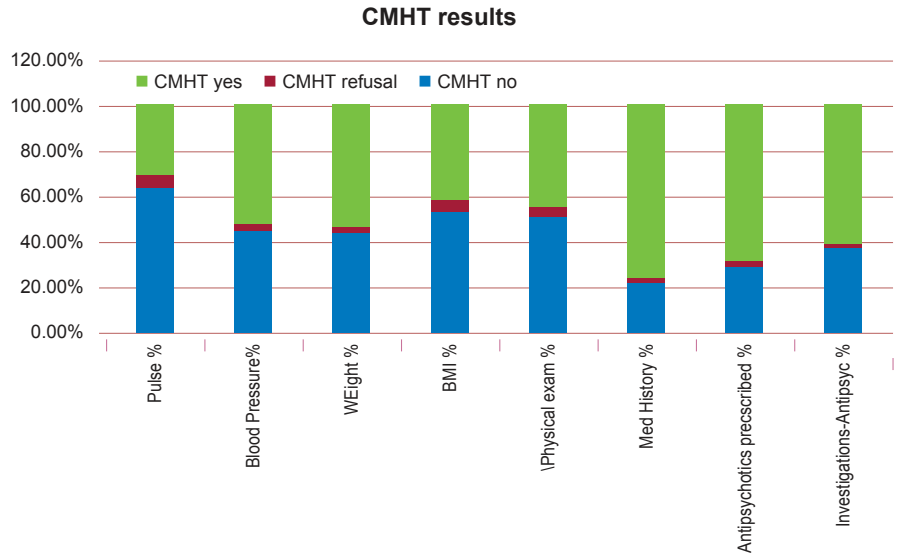


Figure 11: Results of physical health audits by community mental health teams



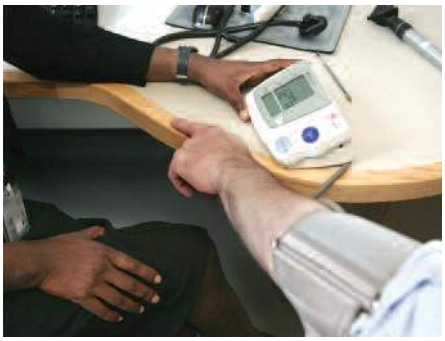
Further update

Assessment of physical health

The assessment of physical health is incorporated into the health and social care document on our integrated care record. This records assessment on the following items:

- Any physical health problems in the past month,
- past medical history,
- family history of physical health problems,
- past hospital admissions, including operations,
- drug treatments, including oral contraception,
- weight (kg without shoes),
- height
- body mass index,
- blood pressure, pulse and SATS.

Based on information derived from the trust's key performance indicator on completeness of the integrated care record, 80 per cent of health and social care assessments were sufficiently completed including the detailed information about the service user's physical health as outlined above.



Electronic recording

The trust is currently transferring our service user records to a new electronic system, from ePex to RiO. The development of the new computer system is being used as another opportunity to develop improved assessment tools.

Physical health link workers

We have established a system of link workers across the trust to support the physical health committee in the implementation of our strategy to improve service users' physical health.

More than 100 clinical staff from all professional disciplines have received enhanced training in various aspects of physical health.

The AGE of Physical Health

This guidance document has been issued across the trust to provide simple but informative information to staff about what needs to be done around assessing and monitoring service users' physical health:

- Assessment and monitoring: Identifies the standard that each service user will have a physical health assessment on admission and at least once per year thereafter.
- Guidance: Identifies the library of local and national guidance documents for physical health
- Equipment: Provides a list of equipment that each area should have in order to assess and monitor physical health.

This complements the green physical health resource folder which has been developed and made available to every clinical team to provide detailed information on pathology, referral triggers, diabetes, falls assessment and management, ECG monitoring, tissue viability, venous assessment and the trust's physical health strategy.

HELP

This year will see the launch of HELP: Health Education Learning Programme for qualified mental health nurses.

This is a joint initiative between our trust and Birmingham City University to further improve the physical health of our service users.

The aim is to equip our nursing staff at Band 5 and 6 with knowledge and skills to provide first class physical health care as part of their routine practice.

Improving liaison with primary care

The trust lead for physical health has delivered training to GP practises and GPs about side effects and comorbidity prevalence. We have also held summits with the GP mental health leads on two

to three occasions to help reinforce this learning.

Our lead has also worked with Birmingham Health and Wellbeing partnership, and subsequently public health now has a seat on our physical health committee.

Our lead has developed a strategic plan for physical health part of which aims to progress the partnership working with GP colleagues.

2.2(c) Patient experience
To improve patient satisfaction in relation to care plan and overall levels of care

How we had done in previous years:
The trust had been making plans to roll out real time feedback mechanisms across services.

We aimed
- To introduce electronic real time feedback mechanisms to drive demonstrable improvements to perceived quality of service by service users.

We planned:
- To confirm a baseline of service user views with the introduction of the new units and use results to identify opportunities for improvement.

So far we have:
- Carried out a pilot of the real time patient feedback.
- Included a carers survey into the real time pilot.
- Evaluated the pilot and identified lessons and improvements.
- Established a timescale for the rollout.
- Introduced a nursing metrics programme.

Further update
Patient Survey results
In the Patient Survey 2011, service users were asked "Overall, how would you rate the care you have received from NHS mental health services in the last 12 months?''

The table below shows the percentage of service users who rated their care between good and excellent.

Table 15: Percentage of service users who rate their care between good and excellent in BSMHFT and all mental health trusts

Birmingham and Solihull Mental Health NHS Foundation Trust	**82%** (up 7% on previous year)
All mental health trusts	**79%**

CQUIN
This project is one of the key requirements for Birmingham and Solihull Mental Health NHS Foundation Trust in 2012/13, and will include regionally determined measurements of service user and carer experience.

Real time feedback pilot
Our trust is committed to gathering and acting upon the feedback that is given to us from our service users and carers.

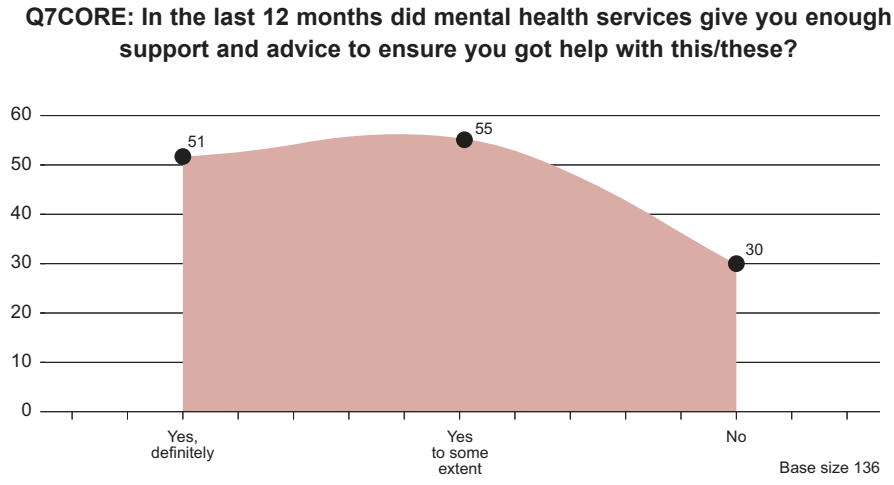
We are continually looking for new, more efficient ways to gather and quickly have access to view these results. We have just completed an eight month pilot of new technologies within the trust including handheld PDAs and kiosks, asking a range of surveys over a number of different sites.

The pilot took place across six pilot sites; Ardenleigh women's service, deaf services at the Barberry, STEPs at the Little Bromwich Centre, Ten Acres, Solihull Integrated Addictions Service (SIAS) at the Bridge and the Zinnia Centre.

Each site has access to up to three handheld devices, one kiosk and one plasma screen, on which the survey results are displayed.

An example of the data real time can generate is shown below:

Figure 12: Sample of real time patient feedback generated by a sample question



Dee Roach, Di Markman and Mark Hillier at the launch of the real-time patient feedback pilot

Comparing this with the feedback from the Patient Survey 2011 (see table 16 below, figures from the national results of the NHS Community Mental Health Service User Survey 2011) enabled us to identify that the teams in the pilot sites were achieving higher levels of service user satisfaction in terms of this support.

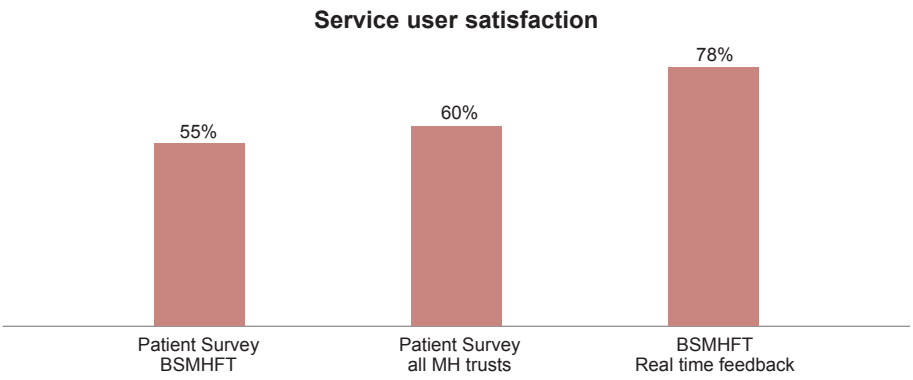
Table 16: Snapshot of results from the NHS Community Mental Health Service User Survey 2011

Area of support	Findings
In the last 12 months, have you received support from anyone in NHS mental health services in getting help with financial advice or benefits (e.g. Housing benefit, income support, disability living allowance)?	**Yes, definitely: 41%** **Yes, to some extent: 18%** No, but would have liked support: 41% I did not need any support : 44%
In the last 12 months, have you received support from anyone in NHS mental health services in getting help with your physical health needs?	**Yes, definitely: 37%** **Yes, to some extent: 28%** No, but would have liked support: 35% I did not need any support : 26%
In the last 12 months, have you received support from anyone in NHS mental health services in getting help with your care responsibilities (including looking after children)?	**Yes, definitely: 32%** **Yes, to some extent: 25%** No, but would have liked support: 43% I did not need any support : 29%
Has anyone in NHS mental health services ever asked you about your alcohol intake?	**Yes: 55%** No: 39% Don't know: 6%
Has anyone in NHS mental health services ever asked you about your use of non-prescription drugs?	**Yes: 39%** No: 49% Don't know: 12%

Source: Patient Survey 2011

This improvement is represented in the chart below

Figure 13: Service user satisfaction: Patient surveys compared to real time feedback



Examples of how we used the data generated by real time during the pilot phase include the following:

- Staff and users worked together on many sites – and wanted to learn more – so designed new surveys into transport, catering and carers issues.
- Ten Acres found that a lot of respondents wanted more support with physical health issues. We were able to support the walking group with pedometers to encourage greater participation.
- The Zinnia Centre teams used the "percentage of users with care plans" graph on their front of house plasma screen – to remind service users and staff of how they were progressing (the results updated live based on service user reports.)
- This approach was also used at Ardenleigh to highlight "percentage of decisions we made about your care which you felt were fair."

We are now evaluating the real time pilot and making our recommendations as to how we will roll out the use of real time patient feedback devices across the organisation.

The pilot has told us many things and broadly speaking we have found:

- The use of real time patient feedback needs to be carried out in a structured, focused way.
- The real time patient feedback initiative should be overseen by a central corporate team, with a central steering group being set up and maintained to decide where patient feedback should be utilised. This work will be supported by service user development workers.
- Requests for use of the patient feedback devices and model should be raised to this group by sites/teams themselves and also at the discretion of this group and direction from service delivery managers and the executive team.
- Patient feedback should be used in different areas of the trust for a set amount of time to look at a certain theme or issue. For example, survey relating to environment for inpatient unit A, survey signed off week one, survey rolled out and inpatient surveyed week two, results gathered, analysed and improvement plan created week three, improvements made week four, real time patient feedback moves on to inpatient unit B. Therefore, kit is not permanently located everywhere, as this approach adds little value.
- A bank of both questions and surveys should be developed and readily available for sites to use, ensuring that surveys are comparable, well worded and correctly structured to enable usable, unambiguous data.
- On the whole, staff and service users liked using the technology, however, careful considerations needs to be taken over issues such as kiosk position and device distribution.

- A key element of success for patient feedback is full engagement from staff, therefore, when rolling out, staff engagement and in-house marketing must be adopted.

Nursing metrics in mental health: Real time patient experience

Nursing metrics provide real time feedback about essential standards of nursing care and are a significant part of the trust's commitment to placing service users at the heart of determining and assessing quality.

Metrics provide an instrument by which good practice can be identified and then shared, while also ensuring resources and attention can be devoted to clinical areas which appear to be underperforming.

A snapshot example of how the nursing metrics dashboard is presented is shown below.

Table 17: Nursing metrics results January 2012 to April 2012

	Jan 2012	Feb 2012	Mar 2012	Apr 2012
NURSING METRICS 1: CARE INDICATORS				
Ward related indicators				
Respect and dignity	71.6% ■	76.5% ↑	83.6% ↑	94.4% ↑
Patient related indicators				
Named nurse coordinated patients' discharge planning meeting?	54.5% ■	75.8% ↑	79.5% ↑	81.0% ↑
Patient experience indicators				
Do you know your named nurse?	71.9% ■	75.4% ↑	80.7% ↑	83.3% ↑

Birmingham and Solihull Mental Health NHS Foundation Trust senior nurses spent time carefully identifying elements of nursing care which are both measurable and meaningful to a many of the diverse group of services users using our services.

Following a successful three month pilot on six wards, a full-scale roll-out of nursing metrics was launched in January 2012. Nursing metrics in Birmingham and Solihull Mental Health NHS Foundation Trust comprise 41 questions divided between three broad areas:

- Care environment,
- patient care, and
- patient experience

Data is collected from each ward in the trust every month by matrons.

A web form was developed by our ICT department in March 2012 to enable real time feedback directly to frontline nurses who can compare their progress and benchmark themselves against neighbouring wards.

This also allows the executive director of quality, improvement and patient experience to assure the trust board about wards which are performing well, and to detail the actions put in place to support underperforming wards.

The next stage of this programme will focus on our community services.

2.3 Summary of priorities for 2012/13

In addition to the new priorities we have decide to roll out our priorities for 2011/12 into the new financial year to see the improvement work through to completion. Therefore for this year our quality account priorities are as follows:

Table 18: Summary of priorities for 2012/13

Domain		Priority
Patient safety	**New**	**To achieve sustainable improvement in the quality of clinical risk assessments**
	Rolled over	Reduce the number and severity of recurring assaults caused by individual patients
Clinical effectiveness	**New**	**To improve quality at each stage of our Care Programme Approach (CPA)**
	Rolled over	Improve reporting of physical health assessments within user records
HFT patient experience	**New**	**To improve engagement of service users in care planning**
	Rolled over	Improve patient satisfaction in relation to care plan and overall levels of care

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 trusts 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 2011/12 Birmingham and Solihull Mental Health Foundation Trust provided or subcontracted 16 NHS 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 services.

The income generated by the NHS services reviewed in 2011/12 represents 100 per cent of the total income generated from the provision of NHS services by Birmingham and Solihull Mental Health NHS Foundation Trust for 2011/12.

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 2011/12 three national clinical audits and one national confidential inquiry covered NHS services that Birmingham and Solihull Mental Health NHS Foundation Trust provides.

During that period Birmingham and Solihull Mental Health NHS Foundation Trust participated in 100 per cent of national clinical audits and 100 per cent of national confidential inquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries that Birmingham and Solihull Mental Health NHS Foundation Trust was eligible to participate in during 2011/12 are as follows:

- National audit of psychological. therapies for anxiety and depression
- National audit of schizophrenia.
- Prescribing Observatory for Mental Health (four audits):
  - 11a – July 2011 Prescribing antipsychotics for people with dementia,
  - 6c – September 2011 Assessment of the side effects of depot antipsychotics,
  - 7c – January 2012 Monitoring of patients prescribed lithium,
  - 10b – March 2012 Use of antipsychotic medication in CAMHS.
- National confidential inquiries into suicide and homicide for people with severe and enduring mental illness.

The national clinical audits and national confidential enquiries that Birmingham and Solihull Mental Health NHS Foundation Trust participated in during 2011/12 are as follows:

- National audit of psychological therapies for anxiety and depression.
- National audit of schizophrenia
- Prescribing Observatory for Mental Health (four audits):
  - 11a – July 2011 Prescribing antipsychotics for people with dementia,
  - 6c – September 2011 Assessment of the side effects of depot antipsychotics,
  - 7c – January 2012 Monitoring of patients prescribed lithium,
  - 10b – March 2012 Use of antipsychotic medication in CAMHS.
- National confidential inquiries into suicide and homicide for people with severe and enduring mental illness.

The national clinical audits and national confidential enquiries that Birmingham and Solihull Mental Health NHS Foundation Trust participated in, and for which data collection was completed during 2011/12 are listed below (where we can provide this information) alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 19: Number of national audits BSMHFT participated in during 2011/12

Audit	Number submitted	Number required
National audit of psychological therapies for anxiety and depression	335	Not specified
National audit of schizophrenia	98	100

The reports of two national clinical audits were reviewed by the provider in 2011/12 and Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- In general results have been circulated to teams for review to inform local practice.
- Further awareness of relevant guidance has been reinforced.
- On review of the national Prescribing Observatory for Mental Health 10b, our board noted that our forensic child and adolescent mental health services achieved 100 per cent compliance in nearly all standards around prescribing antipsychotic medication for children.

The reports of 117 local clinical audits were reviewed by the provider in 2011/12 and Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- We intend to improve the compliance and quality of the Care Programme Approach at each stage in order to improve service user engagement with their own care and outcomes.
- We will develop a quality risk assessment audit tool.
- We will pilot a new approach for medication reconciliation on our inpatient units.
- Included a session around medication reconciliation on the junior doctor induction programme.
- We have produced a clinical guideline for monitoring adverse effects of antipsychotic medication for service users with dementia.
- We have incorporated audit recommendations into the development of our new electronic patient record.

2.4(c) Research

The number of patients receiving NHS services provided or sub-contracted by Birmingham and Solihull Mental Health NHS Foundation Trust in 2011/12 that were recruited during that period to participate in National Institute for Health Research (NIHR) adopted research and approved by a research ethics committee was 870.

Participation in NIHR adopted clinical research demonstrates Birmingham and Solihull Mental Health NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

Birmingham and Solihull Mental Health NHS Foundation Trust was involved in conducting 39 NIHR adopted clinical research studies in during 2011/12. As well, in the past three years, circa 100 publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

2.4(d) Use of CQUIN payment framework

A proportion of Birmingham and Solihull Mental Health NHS Foundation Trust income in 2011/12 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 NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2011/12 and for the following 12 month period are available online at: http://www.monitornhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

In 2011/12 the trust received payment of £2,172,552 (out of £2,172,552) in relation to its CQUIN framework. In 2010/11 the trust received £2,664,000 (out of a potential £2,764,000).

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

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

Birmingham and Solihull Mental Health Foundation Trust has participated in special reviews or investigations by the CQC relating to the following areas during 2011/12:

- Review of compliance (Mary Seacole PICU) July 2011,
- Review of compliance (Eden PICU) July 2011,
- Review of compliance (Caffra unit PICU, Barberry) July 2011,
- Review of compliance (Prison healthcare, HMP Birmingham) January 2012.

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

- Review of compliance (Caffra unit PICU, Barberry): No actions, fully compliant.
- Review of compliance (Mary Seacole PICU):
  - Strengthening arrangements for provision of training to manage and prevent violence.
  - Responding to issues raised by service users in relation to provision of food, activities and environment.
- Review of compliance (Eden PICU): Responding to issues raised by service users in relation to provision of food and environment.
- Review of compliance (Prison Healthcare, HMP Birmingham): Seeking approval with prison authorities to enable medication to be provided at weekends when the prison is in a shutdown situation.

Birmingham and Solihull Mental Health Foundation Trust has made the following progress by March 31, 2012 in taking such action:

- Actions relating to Caffra and Mary Seacole have all been completed and improvements assured.
- The trust is currently in negotiation with prison authorities to enable staff to provide medications at times when the prison is in a shutdown situation at weekends.

The trust's Monitor rating in relation to CQC review is subject to the major concern from the review undertaken in February 2011. This is pending further CQC review.

2.4(f) NHS Number and general medical practice code validity

Birmingham and Solihull Mental Health NHS Foundation Trust submitted records during 2010/11 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:

- 98.6 per cent for admitted patient care;
- 99.7 per cent for outpatient care; and

The percentage of records in the published data which included the patient's valid general medical practice was:

- 100 per cent for admitted patient care
- 100 per cent for outpatient care

Birmingham and Solihull Mental Health Trust will be taking the following actions to improve data quality - continue to monitor and review through our performance management improvement board.

2.4(h) Information governance toolkit attainment levels

Birmingham and Solihull Mental Health Trust information governance assessment report overall score for 2011/12 was 77 per cent and was graded as not satisfactory overall as the trust did not achieve a level 2 on all requirements.

The trust monitors and manages its information governance (IG) compliance through the IG assurance framework; a series of assurance meetings; reporting up to the information governance steering group (IGSG) which is chaired by the Senior Information Risk Owner (SIRO)/director of information and communications technology and attended by key IG staff including the Caldicott Guardian/medical director.

The role of the IGSG is to monitor the trust's compliance with the Connecting for Health IG toolkit, to approve the IG work plan that is developed year on year, in line with the national requirements and manage and lead on risks and issues that are identified throughout the year.

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.

Circles – service user artwork, Phoenix Centre artgroup

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 and one which has been central to 2011/12. Spurred on by national changes to IG requirements the trust has made some key improvements in 2011/12.

Two important areas have been to begin the process rolling and embedding the idea of information asset ownership for systems that process personal data throughout the trust and moving to an annual IG training session for all staff.

The trust has developed its IG considerably over the past year and significant improvements have been made.

Unfortunately there have been some serious incidents in the past year some of which have been reported to the Information Commissioner's Office. These are always fully investigated by key IG stakeholders, and recommendations for improvement made (which are added to the work plan); all of which assists the trust with improving its IG for the future.

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

- Completing roll-out of trustwide data quality training, already delivered to over 70 per cent of staff during 2011/12.
- Completing the implementation of a new clinical information system with many features supporting improved data quality.
- A specific programme of work 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.
- On-going comparison of service user demographic data with the national NHS Summary Care Record database with correction of any discrepancies in our clinical systems.
- Close monitoring of a range of data quality performance indicators with an expanded suite of summary and exception reports made available to both clinical and administrative staff to identify and correct data errors.
- An 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.
- A systematic review of all data quality monitoring processes to ensure fitness for purpose.
- Further improvement of procedures to maintain the accuracy and currency of staff employment details to support operational management and governance activities, following significant development work during 2011/12.

2.4(i) Clinical coding error rate

Birmingham and Solihull Mental Health NHS Foundation Trust was not subject to the payment by results clinical coding audit by the Audit Commission during 2011/12 year.

Part three

3.1 Review of quality of performance

An overview of the quality of care provided by Birmingham and Solihull Mental Health NHS Foundation Trust based on performance in 2011/12 against indicators selected by the board in consultation with stakeholders is presented below with an explanation of the underlying reason for selection.

The arrow highlights an improvement (↑) or reduction in performance (↓). A more detailed explanation of the criteria for each indicator is set out in appendix two.

Table 20: Review of quality performance and care provided by BSMHFT in 2011/12

Domain	Target area	2010/11	2011/12		Comments	Data source	Reason for inclusion
Safety	Health and safety training	68%	90.23%	↑	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 1,000 bed days	32 (Apr – Sep 2010)	39.9 (Apr – Sept 2011 report)	↑	National benchmark (2) • NPSA median 21.1/ 1000 • Birmingham and Solihull Mental Health NHS Foundation Trust in highest 25%	National patient safety benchmark report	This indicates that our staff are reporting and escalating untoward occurrences across the organisation
	Incident reporting timeliness	85% (Dec)	91% (Sep)	↑	This indicator was ceased in September due to implementation of live reporting	Incident reporting system	Timely reporting enables accurate information from which we can learn and improve
	Violence and aggression training	58.8% (Feb)	88% (Mar)	↑	Note final end of year figure for AVERTS five day training	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	↓	Data reflects level of reported physical assaults on staff resulting in injury. This is a reduction in performance, however it may in part be explained by improved reporting across all incidents.	Incident reporting	Level of assaults provides an indicator of safe working for staff and the therapeutic environment.
	Never events*	0	0		No change	Incident reporting	Never events are serious patient safety incidents that are thought to be largely preventable

Comment: The above indicators demonstrate the Birmingham and Solihull Mental Health NHS Foundation Trust's commitment to improving the safety and therapeutic nature of our care environments,
Our new, improved web based system for reporting of incidents is enabling timelier inputting by teams, and will enable better analysis and identification of trends and hot spot areas that may require additional support. We therefore anticipated an increase in the reported number of incidents of violence and aggression.
Core to this is the improved provision of training for our staff in preventing and managing untoward incidents, particularly those involving violence and aggression. Going forward, we anticipate that the improved system of reporting and analysis will enable us to achieve further sustainable reductions.
*National definition: Please see appendix two.

Table 20: Review of quality performance and care provided by BSMHFT in 2011/12 – continued

Domain	Target area	2010/11	2011/12		Comments	Data source	Reason for inclusion
Clinical effectiveness	CRHT % gate kept* admissions	99%	97.7%	↓	National benchmark (1) • Trust 97.34 • Nat mean: 97.35	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%	↑	Trust figure is reflective of benchmark. This is a reduction in performance from 2011/12.	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%	↑	Note: Due to changes in electronic patient information systems the March data does not reflect all services.	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.

Comment: Although we have seen a slight dip in the effectiveness of our home treatment teams in 2011/12, Birmingham and Solihull Mental Health NHS Foundation Trust still exceeds both Care Quality Commission and Monitor targets (greater than or equal to 90 per cent).
In addition to this, our rate of people being delayed in hospital unnecessarily has continued to show sustained reductions.
*National definition: Please see appendix two.

Table 20: Review of quality performance and care provided by BSMHFT in 2011/12 – continued

Domain	Target area	2010/11	2011/12		Comments	Data source	Reason for inclusion
Patient experience	CPA review in previous 12 months %*	95.6%	96.5%	↑	National benchmark (1) • National mean 80.72 (this reflects data from Q3 2010/11).	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*	96.9%	96.2%	↓	National benchmark (1) • 97.16% (Trust is within normal range). This is a slight reduction in performance from 2010/11.		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%	↓		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.
	PALS out of hours				This indicator was ceased due to changes to configuration of PALS service		
	Patient survey – *'Do you have the number of someone to call outside office hours?'*	56%	55%	↓	58% All mental health trusts	NHS Patient Survey	Service users and their families need to know how to access support in case of difficulties arising during evenings or weekends.

Comment: The indicators above reflect the extensive on-going efforts by Birmingham and Solihull Mental Health NHS Foundation Trust to learn from and improve the experience of our service users and carers.
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.
*National definition: Please see appendix two.

Benchmarks

- 1. West Midlands Quality Institute: Quality observatory benchmarking report for mental health trusts
- 2. National Patient Safety Agency: Organisational patient safety report, April–Sept 2011.

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 21: Trust performance against Monitor indicators for 2011/12

Monitor indicators 2011/12	Monitor threshold	2010/11 outturn	2011/12 outturn
1. Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital	95%	96.9%	96.2%
2. Care Programme Approach (CPA) patients receiving formal review in past 12 months	95%	95.6%	96.5%
3. Minimising delayed transfers of care (excluding social care delays)	<7.5%	2.9%	1.9%
4. Admissions to inpatient services having access to crisis resolution home treatments teams	90%	99%	97.7%
5. Meeting commitment to serve new psychosis cases based on trajectories agreed with commissioners	95%	100%	100%
6. MHMDS data completeness: Identifiers recording of NHS number, date of birth, postcode, gender, GP registered code and commissioning code.	99%	99.5%	99.5%
7. Access to healthcare for people with learning disabilities	N/A	Compliant	Compliant
8. Data completeness – outcomes for patients on CPA			
• Percentage discharged with employment status recorded			
• Percentage discharged with accommodation status recorded			
• Percentage having HONOS assessment in past 12 months	50%	79.6%	88.2%

National commissioning targets 2011/12	Threshold	2010/11 outturn	2011/12 outturn
Clostridium difficile infections	0	3	0
MRSA infections	0	0	0
Emergency readmissions – 28 day rate	10.3%	6.34%	6.05%

3.3 Birmingham and Solihull NHS Mental Health Foundation Trust quality strategy

Over recent months we have been working to develop our strategy for quality. Some of the core components are set out below

3.3(a) Quality management framework

The Birmingham and Solihull Mental Health NHS Foundation Trust has a number of systems and processes in place to ensure that the services we provide are of sufficient quality.

Often however, these systems and processes will function independently of each other and as a result may not entirely provide the level of assurance that the organisation and our stakeholders require.

We have therefore been working on a strategic framework for total quality management aimed at integrating our processes into one single system. We aim to implement this during 2012/13.

3.3(b) Quality principles

We have set out our destination statement for quality – which depicts how we will approach quality over the next few years, building on our principles established by our board as detailed below.

Table 22: Quality principles

Principle	Rationale
Service user focus	Birmingham and Solihull Mental Health NHS Foundation Trust and its staff will focus on its service users to understand their current and future needs, to meet their requirements and strive to exceed their expectations. Services will be committed to promoting recovery, so that the individually defined goals of our service users are met and to ensure a service user-focused trust.
Leadership	The top level of Birmingham and Solihull Mental Health NHS Foundation Trust management will direct and support quality improvement activities across the trust. This will involve the creation and maintenance of an environment in which people can become fully involved in achieving the trust's objectives
Employee empowerment	People at all levels of service are the essence of Birmingham and Solihull Mental Health NHS Foundation Trust. Their full involvement will enable their abilities to be used for the benefit of Birmingham and Solihull Mental Health NHS Foundation Trust and its service users.
Process approach	Birmingham and Solihull Mental Health NHS Foundation Trust will achieve desired results through defined processes which embrace the efficient management of resources and activities in a single management system.
System approach to management	We will identify, understand and manage interrelated processes as one system. This will contribute significantly to the effectiveness and efficiency of the trust. The quality improvement framework will be understood, accepted and used across all Birmingham and Solihull Mental Health NHS Foundation Trust services as a result of continuous education and involvement of all levels of staff in quality improvement.
Continual approach	Continuous improvement of the trust's overall performance is a permanent objective of Birmingham and Solihull Mental Health NHS Foundation Trust. We can always find a way to do things better, regardless of how big or small the improvement may be.
Factual approach to decision making	Effective decisions will be made based on the analysis of data and information. Decisions based on fact are likely to be correct.
Mutually beneficial supplier relationships	Birmingham and Solihull Mental Health NHS Foundation Trust and its suppliers are interdependent therefore we will establish mutually beneficial relationships in order to enhance the ability of both to create value.

3.3(c) Quality support team visits

We have established a system of internal review of services. A team of three (a senior manager, a peer manager and a service user representative) will visit a service outside their own area and assess various aspects of quality.

All staff at Band 7 and above are involved, reflecting our ethos that quality is everybody's business. The planned visit involves looking at evidence, speaking with staff and meeting with service users.

This provides an objective view on the service to the local management team, with the offer of support for improvement plans.

The focus is on being supportive and highlighting best practice as well as remedying where improvements are required.

We are currently averaging approximately two quality support team visits to our services per week.

3.3(d) Service initiation approval document

We have worked hard to align our quality planning with existing business planning processes. We have developed a tool for all new initiatives affecting service, for example redesign, new projects, new policy - which integrates three requirements:

- How our quality principles will be reflected and achieved in the work,
- business considerations, and
- equality impact assessment.

3.3(e) Quality and safety programme management board

In 2012/13 we will convene a programme board to oversee quality initiatives across the organisation.

This will enable integrated working across projects and work streams and ensure that our principles are firmly embedded in all the work that we do.

Appendix one

Statements from primary care trusts, Local Involvement Networks (LINks) and Overview and Scrutiny Committees

Primary care trusts

Birmingham and Solihull NHS Cluster
Statement for quality account
Birmingham and Solihull Mental Health NHS Foundation Trust

The Birmingham and Solihull NHS Cluster, as lead commissioner, welcomes the opportunity to provide this statement for the Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) 2011/12 quality account.

This statement has been developed in collaboration with key leads across the Birmingham and Solihull NHS Cluster. Having reviewed the content of the draft quality account in line with the Department of Health guidance we can confirm that it is accurate, balanced and fairly interpreted; the range of services described and priorities for improvement are representative based on the information that is available to us.

We welcome the development of the Birmingham and Solihull Mental Health NHS Foundation Trust quality strategy and particularly the aim for 2012/13 to bring a number of systems and processes into a strategic framework for total quality management into a single integrated system.

The Birmingham and Solihull NHS Cluster leads a monthly Clinical Quality Review Group that holds BSMHFT to account for the quality of services delivered.

This group formally reviews, without limitation, any issues or concerns relating to quality and safety and ensures implementation of any recommendations and requirements for improvement. The information provided in this quality account is consistent with that reviewed by the Clinical Quality Review Group during the year.

On this basis, we can confirm that this account represents a fair reflection of the quality of services provided by the Birmingham and Solihull Mental Health NHS Foundation Trust.

The trust has made a positive move to holding its board meetings in public from April 2012 and we support the aim of this to increase transparency and encourage wider involvement in the business of the trust.

This will enable on going publication of information regarding the quality and outcomes of services and monitoring of these throughout the year.

The work with regard to the real time patient experience feedback pilot supports the cluster priority to deliver a revolution in patient experience and we are very pleased to see the improvements made since last year.

We look forward to the trust driving further improvement in this area through the patient experience goal in the 2012/13 CQUIN scheme. Of particular importance in future is increased attention towards implementing changes in practice and the differences these changes then make to experiences and outcomes of care. We would also recommend an increased focus on reducing health inequalities and ensuring quality for all.

The Birmingham and Solihull NHS Cluster regards the engagement with service users and the public in both service development and in the production of the quality accounts as a high priority.

With this in mind, we are pleased to note that the report is accurate, concise and relatively easy to read and understand.

While the quality account provides a comprehensive and balanced view of relevant indicators our reviewers felt that more reference to the work undertaken to strengthen the links with health visitors and community psychiatric nurses could have acknowledged the developments led by the trust's safeguarding leads.

Recognising the work to date with improving liaison with primary care colleagues our GP leads have also highlighted particularly that they would like to see improved consistency and implementation of agreed documentation across the cluster between primary care and BSMHFT.

In summary, the draft quality account provides a balanced view of the trust's achievements throughout 2011/12 and has set clear priorities for short listing into a final set of quality improvement goals for 2012/13.

Given the challenges ahead and the changes in commissioning arrangements we welcome the further strengthening of our partnership with the trust and development of collaborative approaches to delivering the quality agenda.

Denise McLellan
Chief executive, Birmingham and Solihull NHS Cluster

Local Involvement Networks

Response from Birmingham LINks

It is good to see that the trust remains relentlessly positive about the future, despite difficult times.

We value the fact that improving the quality of service users 'experiences remains a core priority of the trust. The new emphasis on ensuring the service users' physical health needs are assessed and met is particularly welcome.

We hope to continue to work together with the trust in achieving its objectives.

Andrew John
Birmingham LINks

Overview and Scrutiny Committees

Both Birmingham City Council and Solihull Metropolitan Borough Council's overview and scrutiny committees were issued with drafts of the quality report and offered the opportunity to respond formally.

Both responded to indicate that due to the timing of elections and the impact in relation to role and involvement of members that they would be unable to formally respond within the prescribed timescales.

The trust aims to continue dialogue with the committee on the contents of the report and priorities over the coming months.

Annex: Statement of directors' responsibilities

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) 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 2011/12;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2011 to June 2012;
  - Papers relating to quality reported to the board over the period April 2011 to June 2012;
  - Feedback from the commissioners dated May 18, 2012 and May 30, 2012;
  - Feedback from governors dated April 12,2012;
  - Feedback from LINks dated April 26,2012;
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 26, 2011;
  - The latest national patient survey 2011;
  - The latest national staff survey 2011;
  - The head of internal audit's annual opinion over the trust's control environment, dated May 17, 2012 (report to audit committee);
  - CQC quality and risk profiles dated February 2012.

The quality report presents a balanced picture of Birmingham and Solihull Mental Health 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.

Signed

Sue Davis CBE, Chair May 30, 2012

Sue Turner, Chief executive May 30, 2012

Appendix two

Indicator definitions (see section: 3.1)

Safety

- **Health and safety training:** Compliance with mandatory training for health and safety (annual updates for in patient staff).
- **NPSA incident reporting per 1,000 bed days:** Number of incidents reported to national learning system by trust per 1,000 bed days.
- **Incident reporting timeliness:** Incident forms received at risk management office within 14 working days of completion of incident form.
- **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.

Clinical effectiveness

- **CRHT Percentage 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:
  - Admissions to psychiatric intensive care units;
  - 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 they were involved in the decision-making process, which resulted in admission.
- **Anti-psychotics dementia drugs:** Local audits of compliance with NICE guidance.
- **ICR compliance:** Percentage level of completeness of core fields within the patient care record.

Patient experience

- **CPA review in previous 12 months:** Percentage 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 past 12 months.
- **CPA Seven day follow-up:** Percentage 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, or to non-psychiatric care must be followed up within seven days of discharge. All psychiatric patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care, are regarded as being on CPA. All avenues need to be exploited to ensure patients are followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemption: Patients who die within seven days of discharge may be excluded or where legal precedence has forced the removal of a patient from the country. Patients transferred to NHS psychiatric inpatient ward. CAMHS (child and adolescent mental health services) are not included. The seven day period should be measured in days not hours and should start on the day after the discharge.
- **Complaints timeliness:** Percentage of complaints responded within timescale originally agreed with complainant.
- **PALS out of hours:** Number of enquiries out of working hours.
- **Patient survey:** National patient survey results community mental health teams.

Appendix three

How we established priorities for improvement for 2012/13

When considering our priorities for the next year we were mindful of two things:

- That the decision about our priorities should be informed by a review of our services.
- That those who have an interest in our services should help us decide.

To achieve this, we are following the process detailed overleaf.

Table 23: Process followed to establish priorities for improvement in 2012/13

Step one	• Corporate leads were invited to suggest priorities for inclusion in this year's quality account. • We received circa 60 suggestions.
Step two	• Birmingham and Solihull Mental Health NHS Foundation Trust clinical governance committee received the suggestions. • Committee approved the process for creating a shortlist of priorities to inform stakeholder engagement meetings. • Clinical directors and directors for strategic delivery were invited to input to the shortlisting process.
Step three	• A shortlist of three priorities for each domain: Safety, clinical effectiveness and patient experience was established. • This was using a paired comparative approach and was undertaken by trust leads for risk and safety, clinical governance and service user/carer experience.
Step four	• The shortlist will be used to inform our stakeholder engagement with service users and public; Birmingham and Solihull Mental Health NHS Foundation Trust governors; senior management board; staff, volunteers and staff side representatives; commissioners/LINks/OSC; zone clinical governance forums. • A survey was set up on the trust intranet for staff to feedback their thoughts. • An internet survey on the trust homepages was established for service users, carers and wider public to express their views. • Other suggestions for priorities not on the shortlist were welcome.
Step five	• Stakeholder feedback was analysed. • Based on this, final recommendations were made to Birmingham and Solihull Mental Health NHS Foundation Trust clinical governance committee for one new priority per domain. • Committee made recommendations to the trust board for a final decision for the priorities for 2012/13.

Our shortlist for priorities for 2012/13

Safety

- **To reduce the number of medication errors which result in harm to a service user**
  Reducing errors obviously reduces the risk of a service user being harmed in some way and improves the service user's experience of care. The National Patient Safety Agency estimates that preventable harm arising from medication mistakes may cost the NHS around £750 million per year.
- **To improve arrangements for front line clinical staff to provide feedback when they believe that quality of care may be improved**
  Supporting our clinical staff to embrace continuous improvement in quality and safety across our care services.
- **To achieve sustainable improvement in the quality of clinical risk assessments**
  Clinical risk assessment refers to the way in which we systematically gather and analyse information to determine whether harm to a service user (or others) may be likely. It helps us to achieve a safer system of care.

Clinical effectiveness

- **To improve quality at each stage of our Care Programme Approach (CPA)**
  The CPA is a particular way of assessing, planning and reviewing someone's mental health care needs. Making improvements at each stage of the process will ensure a better experience of care and better outcomes for our service users and their carers.
- **To accurately reconcile medication across our care pathways**
  We need to ensure that we have accurate records of service users medications at all points of their journey through our care. This will reduce the risk of mistakes/ omissions and ensures our service users receive the treatment they need.
- **To improve recording of diagnosis in order to enable monitoring and evaluation of clinical interventions**
  It is important that we understand whether the care we deliver reaches the right service users and has positive outcomes. Better recording of each service user's diagnosis will enable us to do and to compare the effectiveness of different types of care for different groups of service users.

Service user experience

- **To improve engagement of service users in care planning**
  Involving service users in decisions about their care is fundamental to achieving a quality experience and improving outcomes.
- **To roll out real time feedback programme**
  Gathering feedback from service users and carers about the care we provide enables us to respond quickly and to make continuous improvements to our services.
- **To engage service users in the assessment of service quality at all levels**
  BMSHFT is committed to engaging our service users in assessing how well our services deliver. This will enable us to ensure that our care systems are focused on the needs of our service users and geared toward providing a quality experience.

Results from the surveys were as follows (highlighted priorities show where staff and public agreed):

Table 24: Results of staff and public surveys against shortlisted priorities

Domain	Shortlisted priorities	Staff survey	Public survey
Patient safety	a) Reduction in the number of medication errors which result in harm to a service user	21.6%	42.9%
	b) To improve arrangements for frontline clinical staff to provide feedback when they believe that quality of care may be improved	**37.8%**	14.3%
	c) Achieve sustainable improvement in the quality of clinical risk assessments priorities	29.7%	**42.9%**
Clinical effectiveness	**a) To improve quality at each stage of our Care Programme Approach (CPA)**	**62.2%**	**85.7%**
	a) To accurately reconcile medication across our care pathways	10.8%	0%
	b) To improve recording of diagnosis in order to enable monitoring and evaluation of clinical interventions	10.8%	14.3%
Patient experience	**a) Improve engagement of service users in care planning**	**56.8%**	**57.1%**
	b) Roll out of real time feedback programme	13.5%	0%
	c) Engage service users in the assessment of service quality at all levels	21.6%	28.6%

Feedback from face-to-face consultation meetings was overwhelmingly in favour of the following:

Table 25: Preferred priorities following face-to-face consultations

Domain	Preferred priority
Patient safety	(c) To achieve sustainable improvement in the quality of clinical risk assessments priorities
Clinical effectiveness	(a) To improve quality at each stage of our Care Programme Approach (CPA)
Patient experience	(a) To improve engagement of service users in care planning

Note: Governor colleagues had favoured item (a) in the patient safety domain.

Alternative suggestions received were as follows:

Table 26: Alternative suggestions for priorities made following face-to-face consultations

Domain	Staff comments	Public
Patient safety	• Reducing the amount of time frontline clinicians spend on inputting data to computers thereby freeing their time for direct patient care. Reducing the number of managers employed by the trust, and their secretaries, PAs, assistants etc, and spending the money on more doctors, nurses, psychologists, occupational therapists, physiotherapists, respite homes, improved ward environments, etc. Stopping the use of clinical budgets to pay managers, and spending the money on direct patient care. • Although all the above is relevant, the main priority for patient safety is correct diagnosis and allocated care path, which ensures most appropriate meds subscription, improve access to clinical staff, which naturally reduce the risk score and assessments. • To ensure risk assessments are completed at regular intervals in line with policy and the results used in care plans and reviews to achieve safer care.	• No alternative suggestions
Clinical effectiveness	• To improve access to psychological therapies. • Drastically reducing expenditure on managers and their supports, and spending the savings on direct patient care. • Robust data systems to inform planning of clinical care and resource allocation. • All the above, you cannot separate, they work hand in hand together; care, meds and monitoring and evaluation. • An amendment to option three: To improve recording of service users' needs and goals in a way that makes clear the links to their symptoms, diagnosis and difficulties and allows us to evaluate the effect of our interventions. Service users do not care if they no longer have a diagnosable mental health problem (if indeed this would ever be possible e.g. dementia is a lifelong diagnosis). They care that their needs are met and that their distress is lessened. Concentrating on diagnostic recording and 'prescribing ' interventions (of any kind) is not consistent with the recovery approach that our trust is promoting. • Improved training for clinicians. • Ensure every patient with a severe and enduring mental illness, receives an annual physical health assessment. This should be happening; I am suggesting we make it happen.	• No alternative suggestions
Patient experience	• Improving patient care by increasing availability of occupational therapists, nurses, psychologists, physiotherapists, doctors. Improving ward and OPC settings. • To inform clinicians, research, and service design/development about the interventions and therapies which are most helpful for service users. To enable clinicians and staff to better understand their role and responsibility in relation to patient care. • It is bullet point number one always, mental health is personal and care is different from one service user to another, it is the only way to improve quality and outcome. Yes, bullet point two and three too, but it is only to set the background scene which is then tailored to suit each service user.	• Consistently poor performers must be sent on communication skill training. • Stamping out punitive nursing

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 (the 'quality report') and specified performance indicators contained therein.

Scope and subject matter

The indicators in the quality report that have been subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital; and
- Admissions to inpatient services having access to crisis resolution home treatments 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 annex 2 to chapter 7 of the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the measurement of the specified indicators in line with the assessment criteria referred to on page 53 of the quality report (the "Criteria").

The directors are also responsible for their assertion and the conformity of their Criteria with the assessment criteria set out in the FT ARM issued by the Independent Regulator of NHS Foundation Trusts ("Monitor"). In particular, the directors are responsible for the declarations they have made in their statement of directors' responsibilities.

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 materially inconsistent 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:

- Board minutes for the period April 2011 to May 2012;
- papers relating to quality reported to the board over the period April 2011 to May 2012;
- feedback from the commissioners dated May 18 2012 and May 30, 2012;
- feedback from LINKS dated April 26, 2012;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 26, 2011;
- the latest national patient survey 2011;
- the latest national staff survey 2011;
- Care Quality Commission quality and risk profiles dated February 2012; and
- The head of internal audit's annual opinion over the trust's control environment, dated 17/5/2012.

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 March 31, 2012, 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 indicator back to supporting documentation.
- Comparing the content requirements of the FT ARM to the categories reported in the quality report.
- 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 two 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:

- 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 materially inconsistent with the sources specified in the guidance; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria.

PricewaterhouseCoopers LLP
Chartered accountants
Birmingham

May 30, 2012

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.

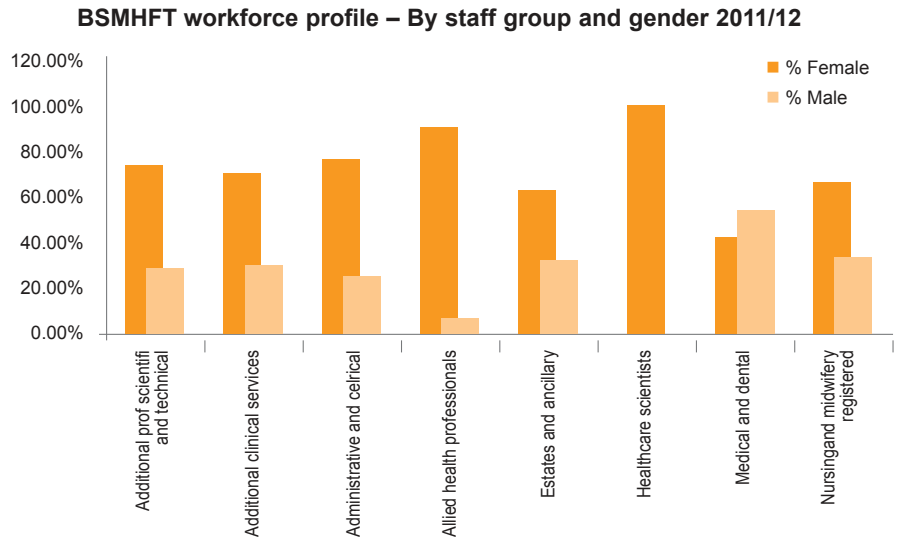
our staff, our greatest asset

Workforce profile

Table 27: BSMHFT workforce profile by staff group and gender 2011/12

Staff group	Female	% Female	Male	% Male	Grand Total
Additional prof scientific and technical	189	72.7%	71	27.3%	260
Additional clinical services	693	70.6%	288	29.4%	981
Administrative and clerical	654	76.0%	207	24.0%	861
Allied health professionals	110	91.7%	10	8.3%	120
Estates and ancillary	102	65.8%	53	34.2%	155
Healthcare scientists	2	100.0%	0	0.0%	2
Medical and dental	122	43.7%	157	56.3%	279
Nursing and midwifery registered	886	68.3%	412	31.7%	1298
Grand Total	**2758**	**69.7%**	**1198**	**30.3%**	**3956**

Figure 14: BSMHFT workforce profile by staff group and gender 2011/12



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.

Table 28: Staff in post: Equality and diversity data for 2011/12

Ethnicity		Trust profile 2009 (%)	Trust profile 2010 (%)	*Trust profile 2011 (%)	Birmingham population %	Solihull population %	**Birmingham and Solihull population %
White	British	54.52	55.29	55.20	65.64	91.27	69.98
Irish		3.90	3.57	3.47	3.22	2.07	3.03
Other White		2.39	2.53	2.50	1.49	1.25	1.45
Mixed	White and Black Caribbean	1.15	1.17	1.29	1.60	0.70	1.45
White and Black African		0.44	0.53	0.48	0.15	0.07	0.14
White and Asian		0.44	0.44	0.53	0.65	0.30	0.59
Other mixed		0.29	0.39	0.38	0.47	0.21	0.42
Asian or British Asian	Indian	5.95	5.86	6.25	5.71	1.82	5.05
Pakistani		2.49	2.50	2.66	10.65	0.49	8.92
Bangladeshi		0.49	0.51	0.61	2.13	0.04	1.78
Other Asian		1.41	1.34	1.29	1.03	0.19	0.89
Black or Black British	Black Caribbean	9.05	9.16	8.93	4.90	0.77	4.19
Black African		6.56	6.29	6.73	0.64	0.11	0.55
Other Black		0.90	0.97	1.04	0.59	0.07	0.51
Chinese	Chinese	0.24	0.27	0.30	0.52	0.34	0.49
Other ethnic group	Other ethnic group	1.15	1.07	1.01	0.63	0.29	0.57
Undefined	Not stated	8.63	8.12	7.34	0.00	0.00	0.00
Grand total		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Table 29: Workforce age profile

Age range	% of headcount
<20	0%
20-29	12%
30-39	26%
40-49	33%
50-59	23%
60-64	5%
65	1%
Grand total	**100%**

Table 30: Sexuality orientation profile

Sexual orientation	Headcount	% of headcount
Bisexual	11	0.28%
Gay	18	0.46%
Heterosexual	1,541	38.98%
Lesbian	17	0.43%
Undisclosed	2,366	59.85%
Grand total	**3,953**	**100%**

Table 31: Gender profile

Gender	Number of staff	Percentage of staff
Female	2,748	69.5%
Male	1,205	30.5%
Grand total	**3,953**	**100%**

Table 32: Religious beliefs profile

Religion	Headcount	% of headcount
Atheism	138	3.5%
Buddhism	11	0.3%
Christianity	1,245	31.5%
Hinduism	45	1.1%
Islam	97	2.5%
Jainism	2	0.1%
Judaism	4	0.1%
Other	141	3.6%
Sikhism	52	1.3%
I do not wish to disclose my religion or beliefs	264	6.7%
Not declared/undefined	1,954	49.4%
Grand total	**3,953**	**100%**

Table 33 Disability profile

Disability	Headcount	% of headcount
No	2,202	55.7%
Not declared/ undefined	1,660	42%
Yes	91	2.3%
Grand total	**3,953**	**100%**

Equality and diversity objectives

In March 2012, the trust board approved a new set of equality and diversity objectives to measure performance April 2012 to April 2014.

The five objectives for this period are:

Data collection: We will ensure that accurate data is collected and held for both staff and service users in each of the nine protected groups by:

– Ensuring that information systems can accurately record data for each of the nine protected groups by August 2012.

– Putting in place information and or awareness campaigns to support the need to record by September 2012.

– Analysing gaps in recording and setting targets for the collection and recording of information where there are gaps by September 2012.

Equality in practise for managers: We will ensure, through a facilitated workshop programme, that all managers are competent to review and analyse the impact of issues relating to equality, diversity and human rights for their teams, and set their own objectives leading to improvements for both staff and service users by April 2014.

Recruitment practice: We will complete a detailed analysis of recruitment practise to understand why current processes show good representation of the local population at application and shortlisting stage, but discrepancies between these figures and numbers appointed. We will establish remedial actions to address issues from this analysis by January 2013.

Assessment and care planning: Through our quality strategy and audit

processes we will ensure that equality diversity and human rights of service users are appropriately identified and where human rights needs are identified appropriate actions are established in a service user's care plan by March 2013.
Patient experience: We will continue to analyse patient feedback through both the patient survey and real time patient feedback systems, ensuring that managers are receiving and able to interpret team-level data to improve the experience of patients in protected groups, and providing an annual report detailing patient experience as it relates to equality, diversity and human rights by April 2013.

Equality steering group
Our equality steering group is responsible for monitoring the progress of the single equality scheme and ensuring that overall standards, targets and objectives are met.

Equality impact assessment
Equality impact assessments are key to ensuring the embedding of equality and diversity across all trust activities. Our approach of applying one impact assessment to all six diversity strands ensure that when ensuring equality for one group we do not disadvantage another. These are published in summary half yearly.

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.

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.

Mandatory 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 tables on pages 60 and 61.

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 2010/11.

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;
- staff support services;
- 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 capacity and capability unit 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.

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 within BSMHFT
"Apprentices are the proven way to train your workforce. Apprenticeships can make your organisation more effective, productive and competitive by addressing your skills gaps directly."
Source: www.apprenticeships.co.uk

Our trust moved into a new field of recruitment in 2009/10 when it began taking on apprentices. 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.

Since then trust staff have worked with individuals to encourage them to join our apprenticeship scheme, to gain work experience, training and qualifications to help them progress to their next role.

As part of our recruitment programme for the trust's new medium secure unit for men, the Tamarind Centre in Bordesley Green, we have taken on eight new apprentices under BSMHFT's first clinical apprenticeship scheme.

The Tamarind Centre will provide assessment, treatment and rehabilitation for men of working age (18 to 65 years), and will increase our provision of

forensic services, alongside existing facilities at Reaside Clinic, Hillis Lodge, Ardenleigh women's service and forensic children and adolescence mental health services.

This new development, which is due to be completed in October 2012, will create more than 300 job opportunities ranging from healthcare assistants to clinical psychologist roles.

Recruitment began in June 2011 and will continue in a phased approach until spring 2013, when the site is expected to be fully operational.

During this time we have also recruited 8.6 (whole time equivalent) apprentices. The clinical apprenticeship scheme was designed to give people of all ages and backgrounds the opportunity to train as healthcare assistants.

Successful candidates have been taken on a 12-month contract on a Band 1 salary, which incorporates workplace learning towards an apprenticeship in health and social care-based within one of our forensic units.

On completion, apprentices will be equipped to apply health care assistant roles within the trust's forensic services.

Encouraging residents from the local community to apply for roles has been a large part of the recruitment plan.

Leaflets have been distributed regularly to residents detailing current vacancies and upcoming opportunities. We have also attended local events to promote jobs at the Tamarind Centre.

A number of existing staff have indicated they would like to move to the Tamarind Centre as part our preference exercise, and we are looking at how best to accommodate these requests as part of our recruitment plans.

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 3.4 per cent by March 2014. These are focused on our key hotspots and targeted at the main underlying causes for sickness absence.

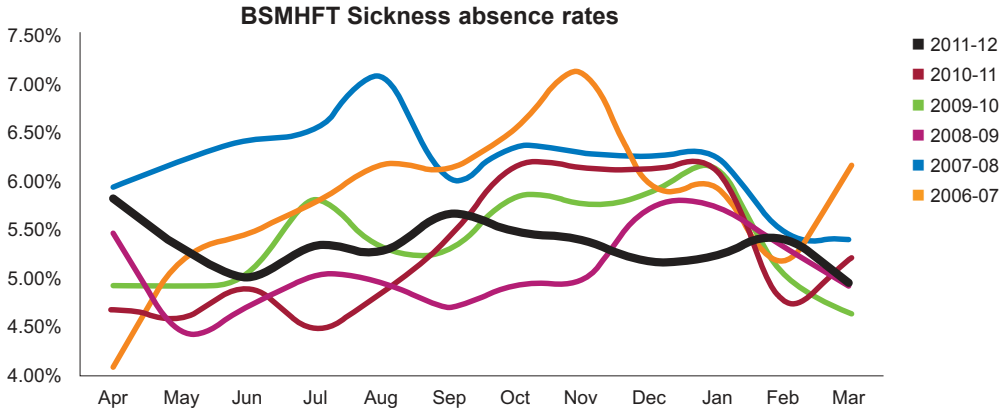
Those are combined with a renewed approach to improving the health and wellbeing of our staff which includes the re provision of our occupational health and staff support services.

BSMHFT sickness absence between 2006/7 and 20011/12

Table 34: Staff sickness absence between 2006/7 and 2011/12

Month	2011-12	2010-11	2009-10	2008-09	2007-08	2006-207
Apr	5.79%	4.66%	4.91%	5.42%	5.92%	4.08%
May	5.30%	4.58%	4.91%	4.44%	6.20%	5.16%
Jun	4.99%	4.88%	5.02%	4.67%	6.40%	5.43%
Jul	5.31%	4.46%	5.77%	5.01%	6.50%	5.75%
Aug	5.26%	4.82%	5.30%	4.94%	7.04%	6.14%
Sep	5.64%	5.39%	5.26%	4.69%	6.01%	6.12%
Oct	5.46%	6.13%	5.82%	4.92%	6.33%	6.53%
Nov	5.37%	6.11%	5.74%	4.97%	6.27%	7.09%
Dec	5.15%	6.10%	5.83%	5.69%	6.23%	5.95%
Jan	5.22%	6.10%	6.11%	5.72%	6.23%	5.91%
Feb	5.39%	4.75%	5.02%	5.30%	5.44%	5.16%
Mar	4.92%	5.19%	4.62%	4.90%	5.40%	6.13%

Figure 15: Staff sickness absence rates 2006/7 to 2011/12



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.

Our future plans for learning and development will see us move towards fully integrated learning and development function, incorporating both clinical and non-clinical training.

Staff engagement

Regular site visits continued in 2011, with directors visiting our community and inpatient teams to engage with staff. This year has seen much greater emphasis on engaging with the workforce on specific projects.

One successful campaign was the strategy for professional nursing. A series of staff workshops and events helped draw out emerging themes, with nursing staff placed at the heart of developing the strategy.

In 2012/13, we will be rolling out the staff engagement and internal communications strategy, which will create a strategic narrative that gives staff a consistent message about the position of our trust. Another element to this strategy is engagement with managers, so they can inspire their staff and give them a voice.

There will also be a focus on recognising good practice and promote knowledge sharing opportunities.

In the past 12 months, the trust has been working on a study to further strengthen and embed staff engagement in all that we do.

National staff survey 2011

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 and service lines within the trust are seeking to address lower scoring results areas that are specific to them.

We have detailed some of those actions below, and we will continue work towards achieving improvements in our staff survey results going forward.

Table 35: Response rate to staff survey 2010/11 and 2011/12

	2010/11		2011/12		Trust improvement/ deterioration
RESPONSE RATE	Trust	National average for mental health and learning disability trusts	Trust	National average for mental health and learning disability trusts	
	54%		54.97%	54%	

Table 36: Top four ranking scores on staff survey 2010/11 and 2011/12

TOP FOUR RANKING	2010/11 Trust	National average for mental health and learning disability trusts	2011/12 Trust	National average for mental health and learning disability trusts	Trust improvement / deterioration
KF1: Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver *(Higher the score the better)*	**74%**	**72%**	**81%**	**74%**	**Increase 7%**
KF 36: Percentage of staff having equality and diversity training in last 12 months *(Higher the score the better)*	**44%**	**57%**	**73%**	**53%**	**Increase 29%**
KF 21: Percentage of staff reporting errors, near misses or incidents witnessed in the last month *(Higher the score the better)*	**94%**	**95%**	**99%**	**97%**	**Increase 5%**
KF 5: Work pressure felt by staff *(Lower the score the better)*	**3.16**	**3.18**	**2.95**	**3.08**	**Positive decrease 0.21**

Table 37: Bottom four ranking scores on staff survey 2010/11 and 2011/12

TOP FOUR RANKING	2010/11 Trust	National average for mental health and learning disability trusts	2011/12 Trust	National average for mental health and learning disability trusts	Trust improvement / deterioration
KF9: Percentage of staff using flexible working options *(Higher the score the better)*	**50%**	**64%**	**52%**	**67%**	**Increase 2%**
KF38: Percentage of staff experiencing discrimination at work in last 12 months *(Lower the score the better)*	**24%**	**14%**	**24%**	**14%**	**No change**
KF 37: Percentage of staff believing the trust provides equal opportunities for career progression and promotion *(Higher the score the better)*	**81%**	**88%**	**81%**	**90%**	**No change**
KF 5: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. (Lower the score the better)	**23%**	**17%**	**18%**	**13%**	**Positive decrease 5%**

Supporting our staff

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 investigations can have a significant impact on staff and have a number of different support mechanisms in place to support staff including a staff support (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 casework data and will now provide this information to directors and service development 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.

Communication with staff

Our trust has seen many changes during 2011/12. We have moved towards devolving decision-making to the frontline, meaning team managers now have more authority and accountability for their areas. Communicating with staff has been an important element of these changes, a series of communications went out to staff, from the chief executive, explaining the move towards devolution and what it means for them.

To support team managers, a number of workshops were arranged to provide training, giving managers the skills to carry out their new responsibilities. Communications featured heavily in these workshops, with an emphasis on encouraging managers to engage with staff and their responsibility in cascading information to staff.

This year has seen a move towards more targeted communications, which has allowed us to be smarter with how we communicate with staff. The annual staff flu campaign has seen an increase in the number of staff vaccinated and was supported by an intensive communications campaign.

During 2011/12 we have rolled out major ICT projects, offering staff improved ways of accessing information. One project has seen the introduction of online training course information statements that has enabled staff to monitor the progress of their training by a simple click of a button. Staff and managers can now see if they are up to date with their training by using the simple traffic light system. This, along with other communications has given us an 80 per cent compliance rate for staff in their statutory and mandatory training requirements, which is a big improvement on previous years.

Over the coming year staff communications will focus on building our internal values, while listening to staff and encouraging debate via two-way communication.

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 governors hold 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 she 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.

A full audit of the board's skill set was conducted in 2010/11 to highlight any areas for development within its collective, with training and development continually undertaken to ensure all members are up-to-date with their skills and requirements

All executive directors and non-executive directors, including the Chair, are appraised annually on their individual performance, and that has been done during the year. Executive directors are permanent appointments, while non-executive directors have a tenure of three years.

Professor Peter Marquis retired from his role as the trust's chairman in September.

Sue Davis, CBE – former Chair of Sandwell and West Birmingham Hospitals NHS Trust (SWBH) - was formally appointed as Chair of BSMHFT in November, following an extraordinary meeting of the Assembly of Governors.

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; and member of the West Midlands Economic Inclusion Panel.

Sue Turner, chief executive
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 PriceWaterhouseCooper. 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
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 chairman of governors at Kidderminster College, chair of Birmingham Community Resource and Information Service, and chairman 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

David Boden, deputy chairman
David was appointed to the board as a non-executive director in October 2006, after serving as chairman on the trust's patient and public involvement forum. For 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 officer 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: Company director (bookmaking and property), magistrate on Sutton Coldfield Bench.

Georgina Dean, acting executive director of resources
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 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.

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.

Denise Roach, executive director of quality, improvement and patient experience

Denise was appointed to her role with our trust in February 2010, having more than 25 years' experience of working in mental health settings.

Denise's previous senior roles include senior director of operations for a large health economy in the north west, 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.

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, Allegra Limited, and chief executive, Elfin Home Care Group.

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 monitoring committee, 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 associate professor, Warwick Medical School; Specialty doctor, Heart of England NHS Foundation Trust; Locum consultant occupational health, Aintree University NHS Foundation Trust; Performance assessor and examiner PLAB, General Medical Council; Member of the editorial board, Society of Occupational Medicine.

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: ic2 Capital, ic2 Capital (PVT) India, Hadley Industries plc, Whiting Landscape Limited, Sahara Group of Companies, member of the Chairman'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, who was appointed as a non-executive director (designate) on January 3, 2012, is chief executive of a company operating in the financial sector. He has particular experience of risk management.

Interests: Executive director, Oval Group.

Joy Warmington, associate non-executive director
Joy Warmington, who was appointed as an associate non-executive director on January 3, 2012, has experience in the public and voluntary sector with particular expertise of regeneration, equality, diversity and education.

Interests: Chief executive officer, BRAP; board member, Be Birmingham Partnership; vice chair, Gateway Family Services; governor, Solihull College; and chair CIN (BBC).

Professor Peter Marquis, former chairman of the trust, retired from his post in August 2011.
Stella Layton, who was a non-executive director, resigned from the trust in November 2011.
Chris Tidman, who was executive director of resources, left the trust in April 2012.

The board met 11 times during 2011/12. Attendance of these meetings is set out in the table below.

Table 38: Trust board attendance 2011/12

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Sue T	y	y	y	y		y	y	y	y	y	y	y
Sue D								y	y	y	y	y
Peter M	n	y	y	y		y						
Chris Tidman	y											
Georgina	y	y	y	y		y	y	y	y	y	y	y
Frances	y	y	y	y		y	y	y	y	y	y	y
Peter L	n	y	y	y		y	y	y	y	y	y	y
Dee	y	y	y	y		y	y	y	y	y	y	y
Stan	y	y	y	y		y	y	y	y	y	n	y
Stella	y	n	n	y		n	n	n				
David	y	y	y	y		y	y	y	y	y	y	y
Sukhbinder	y	y	y	y		y	y	y	y	n	y	y
Alison	y	y	n	n		y	y	y	y	n	y	y
Nerys									y	y	y	y
Joy W										y	y	n
Jeff										y	n	y

Note: The trust board did not meet formally in August, and the February board meeting was held on March 1, 2012.

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 comprises of executive directors and non-executive directors: Sukhbinder Singh Heer (Chair), Frances Allcock, Stan Baldwin, David Boden, Peter Lewis, Alison Lord, Dee Roach, 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 it work programme to the assurance framework to ensure that the major risks facing the trust are mitigated.

The committee meets every six weeks, when at least three of its members are required to be present.

The acting director of finance, medical director, executive director of quality, improvement and patient experience will also attend these meetings, as should 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, 2011 and March 31, 2012.

Table 39: Audit committee attendance 2011/12

Members/Dates	21/4/11	2/6/11	25/8/11	6/10/11	17/11/11	19/1/12	15/3/12
Sukhbinder Singh Heer (Chair)							
Alison Lord		chaired		chaired	chaired		
Stan Baldwin							
Nerys Williams							
David Boden							
Jeff Herdman							
Joy Warmington							
Stella Layton							

Key:
Attended
Apologies given
Deputy attended

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.

The board of directors comprises both executive and non-executive directors, led by the Chair, who by statute also leads the governors. The board are collectively responsible for the running of the trust, exercising powers on behalf of the trust.

Composition of the board 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 Assembly 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 Assembly of Governors

The roles and responsibilities of the Assembly 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 board 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 Assembly 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 Assembly of Governors, and in his or her absence governors should seek the advice of the deputy chair of the trust, acting as senior independent director.

Nomination and remuneration committee

The governors' nomination and remuneration committee met once between April 1, 2011 and March 31, 2012. The meeting was held on the date listed below:

April 26, 2011: Attended by Darren Cooper (chairman), Maureen Johnson, Loris Tapper, Sue Nixon, Frances Allcock, David Boden.

The committee's membership is made up of the trust's Chair and five governors:

- Darren Cooper (lead governor, staff constituency),
- Elsie Gayle (service user constituency),
- Maureen Johnson (public constituency),
- Pat Fleetwood-Walker (carer constituency), and
- Paul Illingworth (stakeholder constituency – Birmingham City University).

A recruitment consultancy was engaged to assist in the process for recruiting a new Chair and non-executive director in 2011. The process followed involved an open selection process in the national press. Assistance with longlisting and shortlisting was received from the external consultancy. Focus groups took place with the Chair interviews with governors, non-executive directors and senior staff, leading to interviews before the nomination and remuneration committee. The committee were also assisted by an external chief executive of a local NHS trust and an external Chair of a local NHS trust. Due to the high calibre of candidates, the governors appointed Dr Nerys Williams to the vacancy, and appointed Jeff Herdman to the role of non-executive director (designate) as one of the existing non-executive directors has indicated an intention to retire in 2012. Joy Warmington was appointed as associate non-executive director.

What do governors do?

All NHS foundation trusts must have an Assembly of Governors to represent 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 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's/chief executive's contract.

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.

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 1274, or by writing to the governor c/o: Governor liaison office, BSMHFT, 50 Summer Hill Road, Birmingham, B1 3RB.

Who can become a governor?

People wishing to be considered as governor candidates must be:

- Aged 18 or over;
- be a member of our trust;
- live within the constituency area they wish to represent; and
- fit the profile of the vacancy – so only service users qualify to stand as a service user governor, likewise for carer, public and staff governor seats.

Governors hold their seats for three ears unless they resign or lose their seat at the next election.

All vacancies and notice of elections are published on our website www.bsmhft.nhs.uk

Governor elections

In 2011 the trust reviewed the governors' constituencies, to widen the areas and reduce the number of governors.

Most of the trust's 21 governors were appointed in July 2008 when the organisation achieved foundation trust status, however the constitution was reviewed in July 2011 to change the constituency boundaries in order to reduce the number of governors, to avoid all being up for election at the same time.

Our governors

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

Public Solihull
Maureen Johnson -
elected in December 2009

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
Elsie Gayle – elected in December 2009

Staff
Darren Cooper (Clinical non-medical) – elected unopposed October 2011
Dr Asaf Khan (Clinical medical) – elected unopposed October 2011
Glen Ward (Non-clinical) – elected unopposed March 2012

Stakeholder
Paul Illingworth (Birmingham City University) – reappointed July 2011
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
Vacancy (PCT representative)

Our board are committed to the views of our governors and members. The governors are invited to attend monthly board meetings to hear the views of the board and comment on trust business.

Furthermore our executive and non-executive directors endeavour to attend Assembly of Governor meetings, network and collaborate with the governors on a regular basis 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. Email gill.harrad@bsmhft.nhs.uk or telephone 0121 301 1085.

Members can contact their governor via a dedicated email address contact.governors@bsmhft.nhs.uk, calling the governor liaison office on 0121 301 1274 or writing to the governor c/o: Governor liaison office, BSMHFT, 50 Summer Hill Road, Birmingham, B1 3RB.

Attendance at Assembly of Governors meetings 2011/12

The board of directors routinely attend Assembly of Governor meetings in order to interact with governors and discuss with them the business of the meeting. Further, all governors of the trust are invited to attend and/or receive papers of the Board meetings including private items.

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

Table 40: Assembly of Governors, governor attendance 2011/12

Assembly of Governors: Governor attendance 2011 / 2012

	Annual plan meeting: May 25, 2011	Assembly of Governors: June 9, 2011	Special meeting of the assembly: June 29, 2011	Special meeting of the assembly: November 14, 2011	Assembly of Governors: December 15, 2012	Assembly of Governors: January 1, 2012
Ali, Khalid						
Anderson, Sue						
Brown,Peter				n/a: not in post	n/a: not in post	n/a: not in post
Cooper, Darren						
Fleetwood-Walker, Patricia						
Gayle, Elsie						
Griffiths, Tessa						
Hemmings, Pat	n/a: not in post	n/a: not in post	n/a: not in post			
Illingworth, Paul						
Innis, Lawrence						
Johnson, Maureen						
Johnson, Mary	n/a: not in post	n/a: not in post	n/a: not in post	n/a: not in post	n/a: not in post	n/a: not in post
Khan, Asaf						
Lea, Peter						
McKenzie, Anne						
Smith, Lynda						
Smojkis, Maureen	n/a: not in post	n/a: not in post	n/a: not in post			
Tinsley, Peter	n/a: not in post	n/a: not in post	n/a: not in post			
Uddin, Faheem						
Ward, Glen	n/a: not in post	n/a: not in post	n/a: not in post	n/a: not in post	n/a: not in post	n/a: not in post

A busy year for our governors

Governors are involved in our services and their input is always valued.

Governors are invited to feed their views into the annual 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, governors opened a member seminar on our pioneering Rapid Assessment, Interface and Discharge service (RAID).

Governors also play an active role in the recruitment of our new Chair, Sue Davis CBE, and non-executive directors, Dr Nerys Williams, Jeff Herdman and Joy Warmington. A sub-committee of governors are responsible for deciding the remuneration and sitting on the interview panel for the Chair and non-executive directors, and the whole assembly ultimately has to approve the recommended appointments.

Under the direction of Sue Davis, and in the spirit of the NHS reforms, governors are becoming increasingly involved 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.

A sub-group of governors works with our communications team to find new and innovative ways to communicate and engage with their members using existing resources. It is hoped that this group will take ownership of a new member e-bulletin that will be launched in 2012.

Governors are kept up to date with the progress of our new Tamarind Centre through site visits and regular updates at Assembly of Governor meetings. It is hoped that they will use their role as governors to engage with the local community as the project nears completion. Governors also attended the official opening of the Juniper Centre in June 2011, having visited the site at various points through construction and having regular updates at governor meetings.

The Assembly of Governors are currently considering how to work efficiently in the future through the use of sub groups, as well as the frequency and duration of meetings.

Reeds: Service user artwork, Phoenix centre art group

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 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 control over the services we provide, 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.

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, the homeless and Birmingham Healthy Minds.

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.

Information on our employees can be found in the chapter – Our staff, our greatest asset – which begins on page 60.

Information governance incidents

In 2011/12 there was a total of 18 information governance-related serious incidents. Three of these were reported to the Information Commissioner, and two 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 and along with the overall improvement in reporting for all incidents, as well as a greater awareness amongst staff of information governance issues, this has further improved reporting of incidents, which helps to explain the increased numbers this year.

Overview of ICO serious incidents:

- Personal data relating to several service users were left at a NHS Shared Services site; when the crates they were in were collected and subsequently emptied.
  The ICO outcome was that no further action would be taken against the trust.
- A clinical diary, trust mobile and two care plans containing details of several clients were stolen when a staff member's car was stolen. Details included names, addresses and phone numbers.
  The ICO is currently investigating and has yet to make a final decision.
- A clinical diary and trust mobile containing details of a number of clients was stolen when a work bag was left in a staff member's car overnight. This incident was reported to the ICO due to the link with the previous incident and the trust's requirement to be open and accountable about any failings in security.

All serious 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 trust's financial performance for the financial year 2011/12. 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 £1.004 million before exceptional items, leading to a financial risk rating of 3 from Monitor. This equates to a score of good for our use of resources.

Going concern

The board of directors considers that the trust 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

This has been a challenging year financially for the trust as well as the wider NHS. We were required to make significant financial savings across our organisation but at the same time safeguard the safety and quality of our services and patient experience. This has meant us looking carefully at how we deliver services and how we work with and support other parts of the NHS. At the beginning of the year we planned a deficit as we were making investments in key schemes the largest being the development of the Tamarind Centre, also we set aside money to pay for the costs of making changes linked to the delivery of our savings.

Initially it was a slow start to the financial year, with divisions getting to grips with what was required of them, however we made progress later in the year, in no small part down to staff in the trust. Our year-end financial position is better than we planned with a surplus of £1.004 million before taking into account exceptional items. Exceptional items included an increase in the valuation of our estate of £3.5m and a reversal of costs we had provided for in 2010/11. The overall position after exceptional items is a surplus of £3.9m. The reason for our 'better than predicted' financial position is down to delays or reduced spending on certain projects, a small contingency fund, and some technical accounting issues. While this has improved our position in year, these do not bring on-going financial benefit.

In year we continued to make investments in key areas where we believe it supports the delivery of our strategic objectives. In 2011/12 we saw significant progress in the construction of the new Tamarind Centre and we began recruitment of staff to work there. Work continues and we remain on track to open in 2012/13. We also began implementation of an electronic care record, this is now being used across the trust with final roll out completed by July 2012.

Other investments included: further investment in our IT infrastructure including tools to support our workforce such as digital dictation and increasing mobility of our staff through wireless connections and hot desking; piloting real time patient feedback devices across the organisation; and continued development for our staff to support devolvement of accountability.

During the year we went through an exercise to reduce our management and to devolve more accountability to front line staff and clinicians. This was supported by training and team development time. Staff have embraced this new way of working and we believe that it has improved transparency and financial control and that it will support the organisation as we move forwards.

Table 41: Financial performance 2010/11 and 2011/12

	2011/12 £'000	**2010/11 £'000**
Income from activities	201,536	208,359
Other operating income	18,616	17,487
Total income	220,152	225,846
Operating expenses	-207,181	-214,488
EBITDA	12,971	11,358
Depreciation	-5,464	-4,284
Revaluation / (Impairments)	3,536	-2,510
(Loss) / Profit on asset disposal	-7	0
Interest received	149	156
Interest payable	-4,971	-4,131
Public dividends payable	-2,257	-2,237
Surplus / (deficit) including exceptional items	**3,957**	**-1,648**
Exceptional items:		
Revaluation / (Impairments)	3,536	-2,510
Costs of exceptional restructuring	-583	-2,599
Operating surplus excluding exceptional items	1,004	3,461
Income and expenditure surplus margin	0.5%	1.5%
EBITDA Margin	5.9%	5.1%

Income

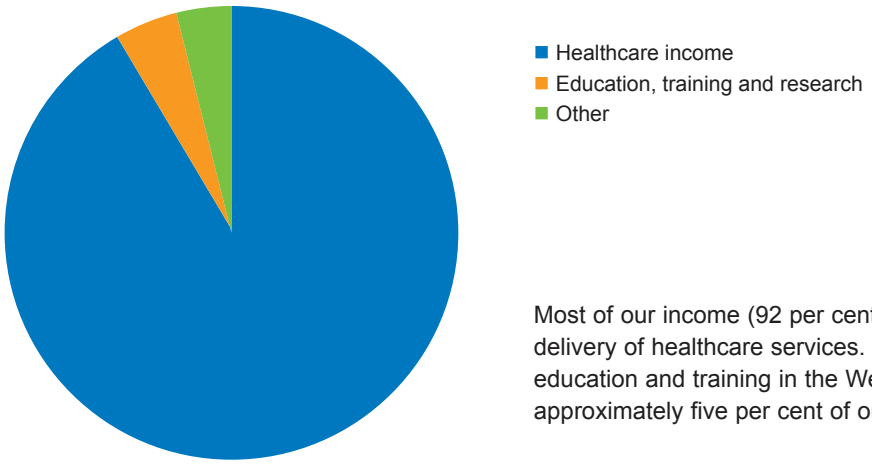
In the financial year 2011/12 the trust generated income of £220 million. This was a reduction from prior year due to a reduction in our contracts of 1.5 per cent applied by our commissioners. This was in line with all NHS providers. In addition we saw further reductions linked to commissioner required savings. The chart below shows a breakdown of our income.

Table 42: BSMHFT's income 2011/12

	Income 11/12	2011/12
Healthcare income	92%	£201,536
Education, training and research	5%	£10,243
Other	4%	£8,373
Total	**100%**	**£220,152**

Figure 16: Where our income comes from

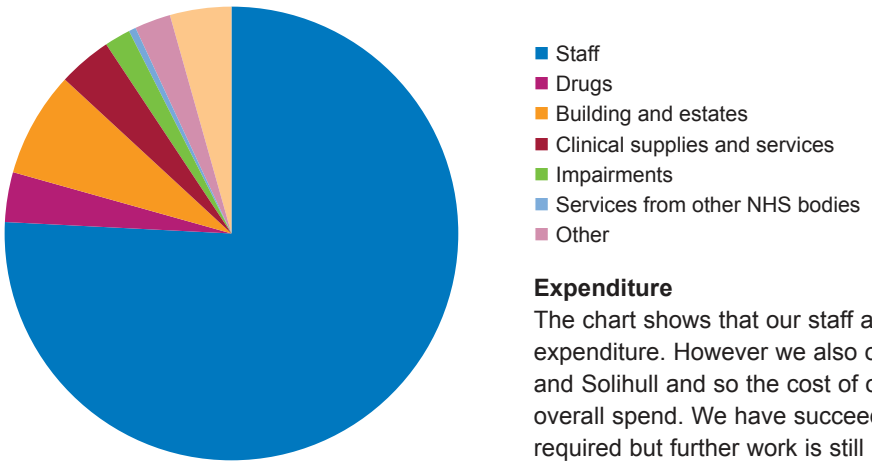
Income



Most of our income (92 per cent) comes from primary care trusts 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 five per cent of our total income.

Figure 17: Trust expenditure for 2011/12

Expenditure



Expenditure

The chart shows that our staff are our most valuable and significant part of our expenditure. However we also operate from over 80 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.

Cash flow

Our trust has reviewed its cash and working capital management with the aim of bringing cash management into line with the commercial cash management arrangements required of foundation trusts.

At the end of the financial year 2011/12, our trust has a cash balance of £35.5 million and an agreed working capital facility of £16 million, showing that the trust's liquidity position remains strong.

In line with the trust's Treasury management policy, we invested cash reserves in selected banks in the year to maximise the interest received

Overview of capital investment and asset values

We invested £24.7m in our assets in 2011/12. The largest investment, £20.4m was in the construction of the Tamarind Centre, our new male medium secure unit. This is being funded through a loan from the Foundation Trust Financing Facility.

We also invested £0.9m in the new electronic care record and £0.3m in development of a community hub for our community services in central Birmingham. There were also a range of smaller schemes to improve the environment, ensure compliance with statutory standards and IT infrastructure.

Due to the changing economic climate, we have reviewed the value of our entire estate. This has resulted in an adjustment to increase the value of our buildings by £6 million. This exercise 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 5.5 per cent of income.

External audit
The trust's assembly 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 is £55,000 excluding VAT. This was the fee for an audit in accordance with the Audit Code issued by Monitor in October 2007.

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.

PriceWaterhouseCooper did not carry out any other work for the trust 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 43: Performance against payment targets 2010/11 and 2011/12

	2011/12 Number	£000 £000	2010/11 Number	£000 £000
Total NHS Invoices paid in the period	618	10,510	713	11,704
Total NHS Invoices paid within target	579	10,005	664	11,091
Percentage of NHS invoices paid within target	**94%**	**95%**	**93%**	**95%**
Total non-NHS invoices paid within period	29,589	64,211	32,662	60,018
Total non-NHS invoices paid within target	28,317	62,909	30,420	57,045
Percentage of non-NHS invoices paid within target	**96%**	**98%**	**93%**	**95%**

There was no interest incurred on late payments, as set out under the Late Payment of Commercial Debts (Interest) Act 1998, during the financial year 2011/12.

Looking forward
Looking forward to 2012/13, the savings and new ways of working must continue. We need to deliver savings of four per cent and we recognise that delivery of savings year on year is tough and delivery of savings while maintaining quality of service is our greatest risk.

We continue to work closely with our commissioners to identify savings and to ensure we jointly understand the impact on services.

We are forecasting a deficit in 2012/13 linked to our investment in the Tamarind Centre. This investment does mean our in year position is tight with little flexibility, however we have strong cash balances and the board believes that this is the right decision as it is in line with our strategic goals. The risks are recognised and mitigating strategies are in place to minimise the impact of these risks.

We are assessing how the Health and Social Care Act will impact on the trust and our services and how we will respond. We recognise that there are risks to us as an organisation but also opportunities. 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 82.

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

Georgina Dean, Executive director of resources, Finance department, B1, 50 Summer Hill Road, Birmingham, B1 3RB.

Statement of the 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 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 S. D. Turner

Sue Turner
Chief executive, Birmingham and Solihull Mental Health NHS Foundation Trust

Date: May 30, 2012

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 on-going 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 March 31, 2012 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 and jointly chair the clinical governance committee.

The medical director has particular responsibility for overseeing the care programme approach, clinical effectiveness, information governance and acts as the Caldicott Guardian. The deputy medical director chairs the information governance steering group, 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.

The trust's finance 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 ICT and facilities has overall responsibility for the trust estate, plant, waste management, fire safety, environmental management and information systems and IT.

Three directors of strategic delivery have delegated responsibility for managing operational risk across the three divisions.

Clinical directors and the other professional heads have responsibility for the systems of risk management at programme or zone level and lead their implementation.

The trust learns from good practice through a range of mechanisms including national guidance and 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 three 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 processes required to manage risk and states the important link to the performance management and business planning systems.

The risk management policy is reviewed by trust board on an annual basis 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 5x5 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 and submitting top risks from this to inform the trust risk register / assurance framework,.

The trust has reviewed itself against the Monitor Quality Governance Framework and identified actions to further strengthen its quality performance. This has led to the development of a quality strategy for the organisation.

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.

Furthermore, the trust aims to systematically review and learn from untoward incidents and complaints. The trust's learning lessons group reports to the clinical governance committee on actions taken in response to trends and themes.

Good practice and changes to policies are communicated through email, intranet, divisional reports, newsletters and team briefs. 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 (NICE), 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 senior information risk owner (SIRO) and attended by key IG staff, including the Caldicott Guardian.

The IGSG monitors the trust's 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 information governance committee endorsed a policy in 2010/11 to mitigate the risks around data security and data loss, and the trust has been highly proactive in ensuring any related incidents are reported swiftly and investigated fully.

A number of incidents in 2011/12 relating to loss of paper records in transit, three of which were reported to the Information Commissioner, have led the trust to investigate further use of technology in community areas to limit the need to transport paper records, and is developing further communications on all areas of IG.

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.
- The trust cost improvement programme has been regularly reviewed and monitored to ensure that targets are met and are sustainable.
- Risks relating to the implementation of a new patient information system in the trust, particularly relating to the impact of having to run two systems in parallel.
- Ensuring compliance with CQC regulations, particularly in relation to safeguarding arrangements.

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.

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 is developing a clinical quality dashboard approach to systematically focus on areas of key clinical risk through the use of a range of clinical quality metrics and performance measures. Further it has established a process of regular internal peer reviews where teams of staff review other services against key quality measures reflecting our national regulation requirements and other standards.

The trust clinical governance committee has continued to focus on exceptions, trends and lessons learned. It also 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 finance committee uses a standard business plan proforma for the review of new developments which is required to demonstrate how risks are managed.

The trust has been implementing a new incident reporting system this year which allows for staff to report incidents electronically and make the reporting of incidents much easier.

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 its sites this year.

Key partners include providers of shared services to the trust, PCTs, other NHS organisations, social care, HMP Birmingham, the police, statutory and voluntary bodies and service user and carer groups.

The assurance framework / corporate risk register is developed via all senior directors of the trust and reported to the board on a quarterly basis. The key risks are used to inform the trust’s annual planning processes.

The assurance framework provides the board with the required assurance that risks to achieving key strategic objectives are being effectively controlled.

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

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

Control measures are in place to ensure that all the 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 3 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 2011/12 has given the trust significant assurance on all key financial systems, including the way in which the trust manages its budgetary control and financial management systems.

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.

The trust board continues to use service line reporting information to inform strategic planning and areas for efficiency improvement.

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 through the year, reflecting wider review and monitoring undertaken by the trust's clinical governance committee and performance management improvement board (PMIB). The PMIB has responsibility within the trust for reviewing the quality of data in relation to key indicators and targets. This process was defined within the core work plan of the clinical governance committee which was approved by the trust board as part of the trust's annual plan.

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, clinical governance 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, and
- 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

I can confirm that this annual governance statement is a balanced reflection of the systems in place during 2011/12.

There are no significant internal control issues identified and the trust believes it has a sound system of internal control that supports the achievement of the organisations plans, aims and objectives.

Signed 

Sue Turner
Chief executive, Birmingham and Solihull Mental Health NHS Foundation Trust

Date: May 30, 2012

Remuneration report

The information in this section is not subject to audit

Remuneration committee

The committee members are:

- Chairman of the committee
- trust Chair
- four non-executive directors

Up until September 2011 the remuneration committee consisted of Professor Peter Marquis, Stella Layton (Chair), Alison Lord, Stan Baldwin, David Boden, and Sukhbinder Singh Heer. As of April 2012, the committee was made up of Sue Davis, CBE (Chair), Stan Baldwin, Sukhbinder Singh Heer, Alison Lord, David Boden, Dr Nerys Williams, Jeff Herdman and Joy Warmington. The trust's chief executive has also attended to advise the committee.

The remuneration committee is a sub-committee of the trust's board, which determines the remunerations, allowances and terms of service of the chief executive and those executive directors reporting directly to the chief executive.

The committee met once during the year on January 17, and was attended by all members. It is chaired by Sue Davis. The work of the committee in 2011/12 was to:

- agree appointment of any executive directors
- to monitor performance and contract terms

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

The salaries paid for senior executive roles in other NHS trusts or in comparable sectors/organisations are taken into account when setting executive pay, however as a result of the difficult economic climate all the trust's executive directors had their pay cut by 4.2 per cent in 2011/12

The committee will monitor and evaluate the performance of the chief executive and the executive directors. 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.

All of the 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 Assembly of Governors approve the removal of non-executives, including the Chair.

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 director of finance.

Our chief executive Sue Turner (appointed April 1, 2003) and executive directors were appointed via rigorous nationwide recruitment processes in line with national and local guidance.

Table 44: Appointments and tenures of non-executive directors

Name and title		Date of first appointment / reappointment 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 to take over Stan Baldwin's NED role when he stands down in September 2012).	03/01/2012
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

Signed S. D. Turner

Sue Turner
Chief executive, Birmingham and Solihull Mental Health NHS Foundation Trust

Date: May 30, 2012

The information in this section is subject to audit

Table 45: Salary and pension entitlements of senior managers – salaries and allowances

Name and title	Year ending March 31, 2012				Year ending March 31, 2011			
	Salary (Bands of £5,000)	Other remuneration (Bands of £5,000)	Benefits in kind (rounded to nearest £100)	Total (Bands of £5,000)	Salary (Bands of £5,000) £'000	Other remuneration (Bands of £5,000) £'000	Benefits in kind (rounded to nearest £100) £	Total (Bands of £5,000)
Sue Turner (Chief executive officer)	165-170	–	–	165-170	170-175	–	–	170-175
Chris Tidman (Deputy CEO / Executive director of resources) (resigned April 27, 2011)	10-15	–	–	10-15	135-140	–	–	135-140
Georgina Dean (Acting executive director of resources) (appointed May 1, 2011)	90-95	–	–	90-95		–	–	–
Peter Lewis (Executive medical director)	100-105	65-70	–	170-175	100-105	60-65	–	165-170
Frances Allcock (Executive director of organisational development and performance improvement)	115-120	–	–	115-120	120-125	–	–	120-125
Denise Roach (Executive director of quality, improvement and patient)	110-115	–	–	110-115	100-105	–	5,900	105-110
Glynis Markham (Executive director of strategic delivery) (appointed December 1, 2003)	95-100	–	–	95-100	–	–	–	–
Peter Marquis (Chairman) (resigned August 30, 2011)	20-25	–	–	20-25	40-45	–	–	40-45
Sue Davis (Chair) (appointed November 28, 2011)	15-20	–	–	15-20	–	–	–	–
Stan Baldwin (Non-executive director)	10-15	–	–	10-15	10-15	–	–	10-15
David Boden (Non-executive director)*	15-20	–	–	15-20	15-20	–	–	15-20
Sukhbinder Heer (Non-executive director)	10-15	–	–	10-15	10-15	–	–	10-15
Alison Lord (Non-executive director)	10-15	–	–	10-15	10-15	–	–	10-15
Stella Layton (Non-executive director) (resigned November 30, 2011)	10-15	–	–	10-15	10-15	–	–	10-15
Nerys Williams (Non-executive director) (appointed December 1, 11)	5-10	–	–	5-10	–	–	–	–
Jeff Herdman (Non-executive director designate) (appointed January 3, 2012)	0-5	–	–	0-5	–	–	–	–
Joy Warmington (associate non-executive director) (appointed January 3, 2012)	0-5	–	–	0-5	–	–	–	–

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

Table 46: Band of highest paid director

Band of highest paid director's total remuneration (£'000)	170-175	170-175
Median total remuneration (£)	27,625	27,534
Ratio	6.2	6.3

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. The median disclosure was calculated by reviewing month 12 gross pay, less any one off items, prorating for 12 months and annualising hours worked to full time pay.

The banded remuneration of the highest-paid director in the trust in the financial year 2011/12 was £170-175k (20010/11, £170-175k). This was 6.2 times (2010/11, it was 6.3) the median remuneration of the workforce, which was £27,625 (2010/11, £27,534).

In 2011/12, one (2010/11, three) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £175-180k (2010/11 - £175-195k). This individual's salary is a result of contract of employment plus additional payment in accordance with national terms and conditions of employment.

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

The ratio has remained relatively consistent with the prior year. This would be expected due to the current pay freeze within the NHS.

Table 47: Pension benefits 2011/12

Name and title	Real increase in pension at age 60 (Bands of £2,500) £'000	Lump sum at age 60 related to real increase in pension (Bands of £2,500) £'000	Total accrued pension at age 60 ending March 31 2012 (Bands of £5,000) £'000	Lump sum at age 60 related to accrued pension at March 31 2012 (Bands of £5,000) £'000	Cash equivalent transfer value at March 31 2012 £'000	Cash equivalent transfer value at March 31 2011 £'000	Real increase in accrued pension during year £'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 April 27 2011)	0-2.5	0-2.5	30-35	100-105	473	348	10
Georgina Dean (Acting executive director of resources) (appointed May 1, 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 and patient)	7.5-10	25-27.5	35-40	110-115	561	355	194
Glynis Markham (Executive director of strategic delivery) (appointed December 1, 2003)	0-2.5	2.5-5	5-10	25-30	0	205	-194

Table 48 Pension benefits 2010/11

Name and title	Real increase in pension at age 60 (Bands of £2,500) £'000	Lump sum at age 60 related to real increase in pension (Bands of £2,500) £'000	Total accrued pension at age 60 ending March 31 2011 (Bands of £5,000) £'000	Lump sum at age 60 related to accrued pension at March 31 2011 (Bands of £5,000) £'000	Cash equivalent transfer value at March 31 2011 £'000	Cash equivalent transfer value at March 31 2010 £'000	Real increase in accrued pension during year £'000
Sue Turner (Chief executive officer)	0-2.5	5-7.5	55-60	175-180	1037	1115	(-78)
Chris Tidman (Deputy CEO / Executive director of resources) Resigned April 27, 2011	0-2.5	2.5-5	30-35	90-95	348	393	(-45)
Peter Lewis (Executive medical director) Appointed June 1, 2009	0-2.5	5-7.5	15-20	45-50	–	–	–
Frances Allcock (Executive director of organisational development and performance improvement) Appointed February 1, 2010	7.5-10	0-2.5	5-10	0-2.5	100	4	96
Denise Roach (Executive director of quality, improvement and patient experience) Appointed February 1, 2010	7.5-10	25-27.5	25-30	80-85	355	292	63

Remuneration received by non- executive members is not pensionable and so this information is not applicable.

Ill health retirements

During the year there were six 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 £405,000.

Independent auditors' report to the Assembly of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust

We have audited the financial statements of Birmingham and Solihull Mental Health NHS Foundation Trust for the year ended March 31, 2012 which comprise the statement of comprehensive income, the statement of financial position, the statement of cash flows, the statement of changes in taxpayers' equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual 2011/12 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 2011/12.

Our responsibility is to audit and express an opinion on the financial statements in accordance with the NHS 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 Birmingham and Solihull Mental Health NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by Birmingham and Solihull Mental Health 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, in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12, of the state of Birmingham and Solihull Mental Health NHS Foundation Trust's affairs as at March 31, 2012 and of its income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion:

- The part of the directors' remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12; 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 2011/12 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 Birmingham and Solihull Mental Health NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- we have qualified our report on any aspects of 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.

Alison Breadon
(Senior Statutory Auditor)
For and on behalf of
PricewaterhouseCoopers LLP
Chartered Accountants and
Statutory Auditors
Cornwall Court,
19 Cornwall Street
Birmingham May 30, 2012

Notes:

(a) The maintenance and integrity of the Birmingham and Solihull Mental Health NHS Foundation Trust website is the responsibility of the directors; 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

Annual Accounts

March 31, 2012

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Foreword to the accounts

These accounts for the year ending March 31, 2012 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.

Chief executive
May 30, 2012

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2011

Statement of comprehensive income

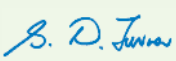
	note	Year ending 2011/12 £000 PRE EXCEPTIONAL ITEMS	Year ending 2011/12 £000 EXCEPTIONAL ITEMS	Year ending 2011/12 £000 TOTAL	As restated Year ending 2010/11 £000 PRE EXCEPTIONAL ITEMS	Year ending 2010/11 £000 EXCEPTIONAL ITEMS	Year ending 2010/11 £000 TOTAL
Operating income	2	220,152	–	220,152	225,846	–	225,846
Operating expenses	4	(212,069)	2,953	(209,116)	(216,173)	(5,109)	(221,282)
OPERATING SURPLUS (DEFICIT)		8,083	2,953	11,036	9,673	(5,109)	4,564
FINANCE COSTS							
Finance income	7	149	–	149	156	–	156
Finance expense	8	(4,971)	–	(4,971)	(4,131)	–	(4,131)
PDC dividends payable		(2,257)	–	(2,257)	(2,237)	–	(2,237)
NET FINANCE COSTS		(7,079)	–	(7,079)	(6,212)	–	(6,212)
SURPLUS / (DEFICIT) FOR THE YEAR		1,004	2,953	3,957	3,461	(5,109)	(1,648)
OTHER COMPREHENSIVE INCOME / (EXPENSE)							
Revaluation gains/(losses) and impairment losses property, plant and equipment				2,839			438
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE PERIOD				6,796			(1,210)

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Statement of financial position

	note	March 31, 2012 £000	As restated March 31, 2011 £000	April 1, 2010 £000
Non-current assets				
Intangible assets	9	–	–	–
Property, plant and equipment	10	202,581	178,368	165,169
Trade and other receivables	12	1,989	1,525	1,172
Total non-current assets		**204,570**	**179,893**	**166,341**
Current assets				
Inventories	11	295	305	460
Trade and other receivables	12	5,091	6,648	4,782
Non-current assets classified as held for sale	10.6	580	–	–
Cash and cash equivalents	21	35,460	33,613	32,097
Total current assets		**41,426**	**40,566**	**37,339**
Current liabilities				
Trade and other payables	13	(23,382)	(23,248)	(18,742)
Borrowings	15	(2,320)	(1,720)	(2,060)
Provisions for liabilities and charges	18	(2,645)	(3,696)	(919)
Other liabilities	14	(9,921)	(9,259)	(10,475)
Total current liabilities		**(38,268)**	**(37,923)**	**(32,196)**
Total assets less current liabilities		207,728	182,536	171,484
Non-current liabilities				
Borrowings	15	(102,328)	(83,647)	(71,512)
Provisions for liabilities and charges	18	(736)	(1,021)	(894)
Total non-current liabilities		**(103,064)**	**(84,668)**	**(72,406)**
Total assets employed		**104,664**	**97,868**	**99,078**
Financed by (taxpayers' equity)				
Public Dividend Capital		100,067	100,067	100,067
Revaluation reserve		23,660	20,879	20,441
Income and expenditure reserve		(19,063)	(23,078)	(21,430)
Total taxpayers' equity		**104,664**	**97,868**	**99,078**

The financial statements on pages 88 to 91 and the associated notes were approved by the board on May 30, 2012 and signed on its behalf by:



(Chief executive)

Date: May 30, 2012

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Statement of comprehensive income

	Total	Public dividend capital	Revaluation reserve	Donated assets reserve	Income and expenditure reserve
	£000	£000	£000	£000	£000
Taxpayers' equity at April 1, 2011 – as previously stated	**97,868**	**100,067**	**20,879**	**–**	**(23,078)**
Prior period adjustment	–	–	–	–	–
Taxpayers equity as 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)**
Taxpayers' equity at April 1, 2010 – as previously stated	**98,928**	**100,067**	**20,441**	**1,884**	**(23,464)**
Prior period adjustment	150	–	–	(1,884)	2,034
Taxpayers' equity at April 1, 2010	**99,078**	**100,067**	**20,441**	**–**	**(21,430)**
Deficit for the year	(1,648)	–	–	–	(1,648)
Revaluation gains and impairment losses property, plant and equipment	438	–	438	–	–
Other transfers between reserves	–	–	–	–	–
Taxpayers' equity at March 31, 2011	**97,868**	**100,067**	**20,879**	**–**	**(23,078)**

As required by the NHS Foundation Trust Annual Reporting Manual 2011/12 the trust has changed its accounting policy for the treatment of donated assets and government grants. Both changes in accounting policy have been applied retrospectively in accordance with IAS 8. Only notes to the statement of financial position that have been affected by the restatement have been presented with additional comparative information.

Donated assets
The impact on the prior year statement of comprehensive income statement was credit of £112k. The opening donated asset reserve of £1,884k was transferred to the income and expenditure reserve.

Government grant
The impact of the prior year statement of comprehensive income statement was a charge of £5k. The opening government grant balance of £150k held within other liabilities was transferred to the income and expenditure reserve.

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Statement of cash flows

	note	2011/12 £000	2010/11 £000
Cash flows from operating activities			
Operating surplus from continuing operations		11,036	4,564
Operating surplus of discontinued operations		–	–
Operating surplus		**11,036**	**4,564**
Non-cash income and expense:			
Depreciation and amortisation	4	5,464	4,284
Impairments	4	682	5,334
Reversals of impairments	4.1	(3,536)	(2,824)
Decrease / (Increase) in trade and other receivables		1,214	(2,219)
Decrease in inventories		10	155
(Decrease) / Increase in trade and other payables		(2,230)	3,602
Increase / (Decrease) in other liabilities		662	(1,216)
(Decrease) / Increase in provisions		(1,336)	2,904
Tax received		–	0
Other movements in operating cash flows		31	–
Net cash generated from operations		**11,997**	**14,584**
Cash flows from investing activities			
Interest received	7	149	156
Purchase of property, plant and equipment	10	(22,416)	(18,362)
Sales of property, plant and equipment		103	–
Net cash generated used in investing activities		**(22,164)**	**(18,206)**
Cash flows from financing activities			
Loans received		20,689	13,790
Capital element of Private Finance Initiative obligations		(1,742)	(2,060)
Interest paid		(845)	(463)
Interest element of Private Finance Initiative obligations	7	(3,792)	(3,603)
PDC dividend paid		(2,296)	(2,526)
Net cash generated from financing activities		**12,014**	**5,138**
Increase in cash and cash equivalents		**1,847**	**1,516**
Cash and cash equivalents at April 1, 2011		**33,613**	**32,097**
Cash and cash equivalents at March 31, 2012		**35,460**	**33,613**

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

1 Accounting policies and other information

1.10 Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2011/12 NHS Foundation Trust Annual Reporting Manual issued by Monitor and EU endorsed IFRS and IFRICSs. 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.

1.2 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 period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

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.

1.5 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.

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

1 Accounting policies and other information (continued)

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.

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
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

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.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:
• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable i.e;
    • management are committed to a plan to sell the asset;
    • an active programme has begun to find a buyer and complete the sale;
    • the asset is being actively marketed at a reasonable price;
    • the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
    • the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met. Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

1 Accounting policies and other information (continued)

Donated, government grant and other grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has 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/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.
The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions
PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-statement of financial position' by the trust. The underlying assets are recognised as property, plant and equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17. The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.
The 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 period, 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.

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

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, eg the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset; and
- the trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware 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, eg application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at fair value.

Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.8 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 stock if considered necessary by management.

1.10 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the 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.

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

1 Accounting policies and other information (continued)

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

Classification and measurement
Financial assets are categorised as fair value through income and expenditure, or loans and receivables. Financial liabilities are classified as fair value through income and expenditure' or as other financial liabilities.

Financial assets and financial liabilities at 'fair value through income and expenditure'
Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities. These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the Statement of Comprehensive Income. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The trust's loans and receivables comprise: current investments, 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 date of the statement of financial performance, 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.

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

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 NHS foundation trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The 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. 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.

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 NHS foundation trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2 per cent in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.8 per cent 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 18.1

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.

1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 18 where an inflow of economic benefits is probable.

• Contingent liabilities are not recognised, but are disclosed in the notes, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.14 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 forecast cost of capital utilised by the NHS foundation trust, is paid over as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5 per cent) on the average relevant net assets of the NHS foundation trust as disclosed in the draft financial statements. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Government Banking Service. Average relevant net assets are calculated as a simple means of opening and closing relevant net assets.

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

1 Accounting policies and other information (continued)

1.15 Taxation

Value Added Tax

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

Corporation Tax

Healthcare activities of the NHS foundation trust are outside the scope of Corporation Tax. Application of Corporation Tax to NHS bodies has been deferred beyond March 31, 2012.

1.16 Foreign exchange

The functional and presentational currencies of the trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Where the trust has assets or liabilities denominated in a foreign currency at the date of the statement of financial position:

• monetary assets and liabilities (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on March 31, 2012;

• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and

• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the statement of financial position date) are recognised in income or expense in the period in which they arise. Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.18 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 financial statements:

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 in 2012/13.

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.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

1 Accounting policies and other information (continued)

1.19 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. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

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 to the application of IAS27 in relation to the consolidation of NHS Charitable Funds for 2010/11 and 2011/12, the charity has not been consolidated into these financial statements.

1.20 Accounting standards issued but not yet adopted

The following accounting standards have been issued but have not yet been adopted. NHS bodies cannot adopt new standards unless they have been adopted in the HM Treasury FReM. The HM Treasury FReM generally does not adopt an international standard until it has been endorsed by the European Union for use by listed companies. In some cases, the standards may be interpreted in the HM Treasury FReM and therefore may not be adopted in their original form. The analysis below describes the anticipated timetable for implementation and the likely impact on the assumption that no interpretations are applied by the HM Treasury FReM.

i) IFRS 7 - Financial instruments: Disclosures

This is an amendment to the standard to require additional disclosures where financial assets are transferred between categories (eg Fair value through profit and loss, loans and receivable etc). It is applicable from 2012/13. It is unlikely to affect NHS bodies as they rarely transfer financial instruments.

ii) IFRS 9 - Financial instruments

This is a new standard to replace IAS 39 Financial instruments: Recognition and measurement. Two elements of the standard have been issued so far: Financial assets and financial liabilities. The main changes are in respect of financial assets where the existing four categories will be reduced to two: Amortised cost and 'Fair value through profit and loss'. At the present time it is not clear when this standard will be applied because the EU has delayed its endorsement. The impact on the trust will not be significant.

iii) IAS 1 Presentation of financial statements (Other comprehensive income)

This standard is applicable for periods beginning on or after July 1, 2012, the standard has not yet been EU endorsed

iv) IAS 12 - Income taxes (amendment)

This standard is applicable for periods beginning on or after January 1, 2012 but the standard has not yet been EU endorsed.

v) IAS 19 Post-employment benefits (pensions) - this standard is applicable for periods beginning on or after January 1, 2013, the standard has not yet been EU endorsed

vi) IAS 27 Separate financial statements (Revised 2011)

this standard is applicable for periods beginning on or after January 1, 2013, he standard has not yet been EU endorsed.

vii) IAS 28 Investments in associates and joint ventures (Revised 2011)

This standard is applicable for periods beginning on or after January 1, 2013, he standard has not yet been EU endorsed.

viii) IAS 32 Financial instruments: Presentation on offsetting financial assets and financial liabilities

This standard is applicable for periods beginning on or after January 1, 2014.

ix) IFRS 1 - 'First time adoption', on hyperinflation and fixed dates

This standard is applicable for periods beginning on or after July 1, 2011 he standard has not yet been EU endorsed.

x) IFRS 10 Consolidated financial statements

This standard is applicable for periods beginning on or after January 1, 2013, the standard has not yet been EU endorsed.

xi) IFRS 11 Joint arrangements

This standard is applicable for periods beginning on or after January 1, 2013, the standard has not yet been EU endorsed.

xii) IFRS 12 Disclosure of interests in other entities

This standard is applicable for periods beginning on or after January 1, 2013, the standard has not yet been EU endorsed.

xiii) IFRS 13 Fair value measurement

This standard is applicable for periods beginning on or after January 1, 2013, the standard has not yet been EU endorsed.

xiv) IPSAS 32 - Service concession arrangement

This standard is applicable for periods beginning on or after January 1, 2014 but as it is not an IFRS standard it will have to be endorsed by HM Treasury as part of the HMT FReM before it is adopted.

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

1 Accounting policies and other information (continued)

b) Other changes
HM Treasury has granted dispensation to the application of IAS 27 (revised) by NHS foundation frusts 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.

1.21 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 trust"s financial performance including, but not limited to, material asset impairments and material costs of restructuring.

1.22 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.

1.23 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.

1.24 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.

2.0 Operating Income by classification

	2011/12 £000	2010/11 £000
Income from activities		
Cost and volume contract income	64,651	137,336
Block contract income	136,885	71,023
Total income from activities	**201,536**	**208,359**
Other operating income		
Research and development		
Education and training	10,243	9,742
Non-patient care services to other bodies	4,089	2,675
Other *	4,284	5,070
Total other operating income	**18,616**	**17,487**
Total operating income	**220,152**	**225,846**

*Other income includes £0.8m relating to funding set up cost for Yardley Green (2010-11 £0.7m), £0.4m relating to income received for recharge of drugs (2010-11 £nil), £0.2m relating to psychology services (2010-11 £0.2m) and other miscellaneous income.

2.1 Income from activities from mandatory services

	2011/12 £000	2010/11 £000
Income from activities arising from mandatory services	197,941	205,235
Income from activities arising from non-mandatory services	22,211	20,611
	220,152	**225,846**

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

2.2 Private patient income	**2011/12 £000**	**2010/11 £000**	**Base Year £000**
Private patient income	–	–	–
Total patient related income	201,536	208,359	208,359
Proportion (as percentage)	**0.00 %**	**0.00 %**	**0.00 %**

Section 44 of the 2006 Act requires that the proportion of private patient income to the total patient related income of the NHS foundation trust should not exceed its proportion whilst the body was a NHS Trust in 2002/03 or in the base year. Monitor has reset this proportion as 1.5 per cent from January 2010.

3 Operating segments

The provision of NHS healthcare is the core activity of the trust. The trust is structured into three divisional areas, Adult of working age; Youth, addictions, the homeless and Birmingham Health Minds; and Secure and complex care. The results of these three divisions have been aggregated into a single operating segment as the divisions have similar economic characteristics, the nature of the services they provide are similar (free NHS healthcare), they have a similar client base (general public from local areas), and they have the same regulators (Monitor, Department of Health and the Care Quality Commission). In addition the board, which is considered to be the chief operating decision maker for segmental analysis, reviews performance and allocates resources based on the performance of the trust as a whole.

The corporate functions of the trust only earn revenues which are incidental to the activities of the trust and are not derived from provision of NHS healthcare. For this reason, corporate results are not considered to be a separate segment but have been disclosed below to reconcile segmental results to a trustwide total.

Information on the trust's position is reviewed on a trustwide basis by the board therefore no segmental information on total assets or liabilities is disclosed in this note. The disclosure below is consistent with the information reviewed by the chief operating decision maker.

The trust generates all of its healthcare revenue from other NHS entities. These other NHS entities are considered to be under common control and are therefore considered to be one single customer for segmental reporting purposes. Healthcare revenue from NHS entities is received across all reportable segments. All revenue is generated from within the UK.

		2011/12		
	Healthcare income £000	**Corporate £000**	**Other reconciling items £000**	**Total £000**
Income	201,536	–	–	201,536
Depreciation	(3,723)	(1,741)	–	(5,464)
Interest revenue	–	149	–	149
Interest expense	(4,971)	–	–	(4,971)
Surplus / (deficit)	(173,229)	173,650	3,536	3,957

		2010/11		
	Healthcare income £000	**Corporate £000**	**Other reconciling items £000**	**Total £000**
Income	206,068	3,041	(750)	208,359
Depreciation	(2,644)	(1,640)	–	(4,284)
Interest revenue	–	156	–	156
Interest expense	(4,131)	0	–	(4,131)
Surplus / (deficit)	22,047	(21,116)	(2,579)	(1,648)

The reconciling items relate to impairment of property, plant and equipment (and final adjustments made to the final year end financial statements in 2010/11) which are not allocated in segmental information reviewed by the board.

The difference in magnitude between the surplus / (deficit) made between trustwide and corpoate in the current and prior year is due to the allocation of healthcare contracts as viewed by the board.

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

4 Operating expenses

	2011/12 £000	2010/11 £000
Services from NHS foundation trusts	1,901	2,015
Services from NHS trusts	3,488	775
Services from other NHS bodies	231	3,263
Employee expenses: Executive directors	901	817
Employee expenses: Non-executive directors	133	130
Employee expenses: Staff	158,579	167,204
Drug costs	7,502	7,376
Supplies and services: Clinical (excluding drug costs)	376	359
Supplies and services: General	3,852	4,278
Establishment	4,461	4,398
Research and development -	-	
Transport	1,165	1,147
Premises	13,996	12,787
Increase in bad debt provision	309	343
Termination benefits	1,344	–
Depreciation on property, plant and equipment	5,464	4,284
Amortisation on intangible assets		–
Impairments of property, plant and equipment	682	–
Impairments of intangible assets		–
Reversal of impairments of property, plant and equipment		–
Reversal of impairments of intangible assets		–
Audit fees (note 4.3)		
Audit services - statutory audit	90	79
Other auditors remuneration		
Other services	–	1
Clinical negligence	478	408
Loss on disposal of land and buildings		–
Loss on disposal of other property, plant and equipment	7	–
Other	7,110	6,509
TOTAL	**212,069**	**216,173**

4.1 Exceptional items

	2011/12 £000	2010/11 £000
Impairments of property, plant and equipment	–	5,334
Reversal of impairments of property, plant and equipment	(3,536)	(2,824)
Termination benefits	583	2,599
TOTAL	**(2,953)**	**5,109**

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 in 2011/12 includes a credit of £1.2m (2010-11 £nil) relating to the release of a provision recognised as exceptional in the prior year.

4.2 Analysis of loss on disposal

	2011/12 Total £000	2010/11 Total £000
Disposal of non-protected assets	7	–
TOTAL	**7**	**–**

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

4.3 Auditor remuneration

The Assembly of Governors appointed PricewaterhouseCoopers LLP (PwC) as external auditors of the trust for the three years commencing 2010/11. The audit fee for the statutory audit was £65,000 (2011/12 £67,000) excluding VAT. The current year charge within operating expenses also includes £10,000 relating to the audit of the quality accounts not accrued in the previous year. 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

	2011/12 £000	2010/11 £000
Minimum lease payments	1,852	1,945
Contingent rents	–	–
TOTAL	**1,852**	**1,945**

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 £1.6m which is included within operating costs. The leases for vehicles and equipment range from 1 to 5 years and have an annual charge of £0.2m which is included within operating costs.

The trust's 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 £0.4m. 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.

4.5 Total future minimum lease payments

	2011/12 £000	2010/11 £000
Not later than one year	2,001	1,526
Later than one year and not later than five years	4,050	4,183
later than five years	10,959	11,143
TOTAL	**17,010**	**16,852**

5 Directors' remuneration

	2011/12 Total £000	2010/11 Total £000
Directors' remuneration	827	765
Social security costs	106	88
Employer contributions to a pension scheme in respect of directors'	101	94
TOTAL	**1,034**	**947**

The medical director was paid £69k (2010-11 £63k), which is not included in the above disclosure, for his non-director responsibilities.

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

5.1 Directors' advances

No liabilities under guarantees.	2011/12 Total £000	2010/11 Total £000
Amounts due from / (to) directors:	4	9
	4	**9**

The advance, for relocation costs, made to the director is interest free and due to be paid in 2012/13.

6 Employee expenses

(including executive directors but excluding non-executive directors)	2011/12 Total £000	2010/11 Total £000
Salaries and wages	129,867	135,179
Social security costs	10,346	10,269
Employers contributions to NHS pensions	14,864	15,325
Termination benefits (see note 4.1)	1,927	2,599
Agency/contract staff	4,509	7,363
	161,513	170,735
Less capitalised cost	(106)	(115)
TOTAL RECOGNISED IN OPERATING EXPENSES	**161,407**	**170,620**

6.1 Average number of employees (WTE basis)

	2011/12 Number	2010/11 Number
Medical	273	261
Administration and estates	601	596
Healthcare assistants and other support staff	769	802
Nursing and health visiting staff	1,267	1,311
Scientific, therapeutic and technical staff	479	551
Other	289	274
TOTAL	**3,678**	**3,795**

6.2 Early retirements due to ill health

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. The information has been supplied by the NHS Pensions and these costs are not borne by the foundation trust.

	2011/12 £000	2011/12 Number	2010/11 £000	2010/11 Number
No of early retirements on the grounds of ill health		6		7
Value of early retirements on the grounds of ill health	405		785	

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

6.3 Staff exit packages

Exit package cost band	Number of compulsory redundancies	Number of other agreed departures	Total number of exit packages by cost band	Total number of exit packages by cost band
	2011/12	**2011/12**	**2011/12**	**2010/11**
<£10,000	15	–	15	6
£10,000 - £25,000	29	–	29	5
£25,001 - £50,000	20	–	20	5
£50,001-£100,000	13	–	13	1
£100,001 - £150,000	6	–	6	0
£150,001 - £200,000	2	–	20	
Total number of exit packages by type	85	0	85	17
Total resource cost £'000	3,170	0	3,170	352

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

	2011/12 £000	**2010/11 £000**
Interest on loans and receivables	149	156
TOTAL	**149**	**156**

8 Finance costs

	2011/12 £000	**2010/11 £000**
Loans from the Foundation Trust Financing Facility	1,179	528
Finance costs in PFI obligations		
Main finance costs	3,081	3,162
Contingent finance costs	711	441
TOTAL	**4,971**	**4,131**

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

9 Intangible assets	Total	Softeware licences (purchased)	Licences and trademarks (purchased)
	£000	£000	£000
Cost or valuation at April 1, 2010; April 1, 2011; March 31, 2011 and March 31, 2012	**274**	–	253
Accumulated amortisation at April 1, 2010; April 1, 2011; March 31, 2011 and March 31, 2012	**274**	–	253
Net book value			
NBV - Purchased at March 31, 2011 and March 31, 2012	–	–	–
NBV - Donated at March 31, 2011 and March 31, 2012	–	–	–
NBV total at March 31, 2011 and March 31, 2012	–	–	–

10 Property, plant and equipment March 31, 2012	Total	Land	Buildings excluding dwellings
	£000	£000	£000
Cost or valuation at April 1, 2011 as previously stated	**185,380**	48,287	118,962
prior period adjustments	–		
Cost or valuation at April 1, 2011	**185,380**	48,287	118,962
Additions - purchased	**24,698**		1,853
Additions - donated	–		
Acquisition through business combination	–		
Impairments charged to revaluation reserve	2,839	15	2,824
Reclassifications	–		
Revaluation surpluses	–		
Transfers to non-current assets classified as held for sale (note 10.6)	(580)	(580)	
Transfers from accumulated depreciation*	(510)		(436)
Disposals	(134)		(25)
Cost or valuation at March 31, 2012	**211,693**	**47,722**	**123,178**
Accumulated depreciation at April 1, 2011 as previously stated	**7,012**	–	–
prior period adjustments	**–**		
Accumulated depreciation at April 1, 2011	**7,012**	–	–
Accumulated depreciation at start of period for new FTs	–		
Provided during the year	**5,464**		3,342
Acquisition through business combination	–		
Impairments recognised in operating expenses	682	595	87
Reversal of impairments	(3,536)		(3,501)
Reclassifications	–		
Revaluation surpluses	–		
Transferred to cost or valuation*	(510)		(436)
Disposals	–		
Accumulated depreciation at March 31, 2011	**9,112**	–	–
Net book value			
NBV - Purchased at March 31, 2011	**176,372**	47,137	118,170
NBV - Donated at March 31, 2011	**1,996**	1,150	792
NBV total at March 31, 2011	**178,368**	**48,287**	**118,962**
Net book value			
NBV - Purchased at March 31, 2012	**200,501**	46,572	122,290
NBV - Donated at March 31, 2012	**2,080**	1,150	888
NBV total at March 31, 2012	**202,581**	**47,722**	**123,178**

*These lines represent the elimination of accumulated depreciation against the carrying value of assets which have been revalued in the year in acco

The net book value of assets held under finance lease arrangements is £47,868k (2010/11 £46,347k). Depreciation of £865k (2010/11 £834k) was ch

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

Patents (purchased) £000	Information technology (internally generated) £000	Development expenditure (internally generated) £000	Other (purchased) £000	Other (internally generated) £000	Goodwill £000
–	–	21	–	–	–
–	–	21	–	–	**–**
–	–	–	–	–	–
–	–	–	–	–	–
–	–	–	–	–	–

Dwellings £000	Assets under construction and POA £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000
375	5,192	3,342	93	5,344	3,785
375	5,192	3,342	93	5,344	3,785
	21,304	10		1,483	48
	(1,634)			1,634	
13	(87)				
				(109)	
388	**24,775**	**3,352**	**93**	**8,352**	**3,833**
–	–	1,927	93	2,423	2,569
–	–	1,927	93	2,423	2,569
22		249		1,515	336
(35)					
13	(87)				
–	–	**2,176**	**93**	**3,938**	**2,905**
375	5,192	1,361	–	2,921	1,216
–	–	54	–	–	–
375	**5,192**	**1,415**	–	**2,921**	**1,216**
388	24,775	1,134	–	4,414	928
–	–	42	–	–	–
388	**24,775**	**1,176**	–	**4,414**	**928**

rdance with IAS 16 - Property, Plant and Equipment.

harged on these assets in the year. These assets wholly relate to PFI assets

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

10.1 Analysis of property, plant and equipment March 31, 2012	Total	Land	Buildings excluding dwellings
	£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
Total at March 31, 2012	202,581	47,722	123,178

Property, plant and equipment is classified as protected if it is required for the purposes of providing either mandatory goods and services or mandato

10.2 Property, plant and equipment at March 31, 2011	Total	Land	Buildings excluding dwellings
	£000	£000	£000
Cost or valuation at April 1, 2010 as previously stated	**208,413**	51,114	139,832
prior period adjustments	–		
Cost or valuation at April 1, 2010	**208,413**	51,114	139,832
Additions - purchased	**19,555**	–	2,732
Additions - donated	–		
Acquisition through business combination	–		
Impairments charged to revaluation reserve	**(1,658)**	(1,752)	94
Reclassifications	–	–	16,118
Revaluation surpluses	**2,276**	390	1,886
Transfers from accumulated depreciation*	**(43,179)**	(1,465)	(41,700)
Disposals	**(27)**	–	–
Cost or valuation at March 31, 2011	**185,380**	**48,287**	**118,962**
Accumulated depreciation at April 1, 2010 as previously stated	**43,244**	–	37,337
prior period adjustments	–		
Accumulated depreciation at April 1, 2010	**43,244**	–	37,337
Accumulated depreciation at start of period for new FTs	–		
Provided during the year	**4,284**	–	3,109
Acquisition through business combination	–		
Impairments recognised in operating expenses	**5,334**	1,465	3,869
Reversal of impairments	**(2,824)**	–	(2,795)
Reclassifications	–	–	–
Revaluation surpluses	–	–	–
Transferred to cost or valuation*	**(42,999)**	(1,465)	(41,520)
Disposals	**(27)**	–	–
Accumulated depreciation at March 31, 2011	**7,012**	**–**	**–**
Net book value			
NBV - Purchased at March 31, 2010	**163,285**	49,964	101,828
NBV - Donated at March 31, 2010	**1,884**	1,150	667
NBV total at April 1, 2010	**165,169**	**51,114**	**102,495**
Net book value			
NBV - Purchased at March 31, 2011	**176,372**	47,137	118,170
NBV - Donated at March 31, 2011	**1,996**	1,150	792
NBV total at March 31, 2011	**178,368**	**48,287**	**118,962**

*These lines represent the elimination of accumulated depreciation against the carrying value of assets which have been revalued in the year in acco

The net book value of assets held under finance lease arrangements is £46,347k (2009/10 £44,744k). Depreciation of £834k (2009/10 £1,071k) was

10.3 Analysis of property, plant and equipment at March 31, 2011	Total	Land	Buildings excluding dwellings
	£000	£000	£000
Net book value			
NBV - Protected assets at March 31, 2011	**139,599**	31,330	108,269
NBV - Unprotected assets at March 31, 2011	**38,769**	16,957	10,693
Total at March 31, 2011	**178,368**	**48,287**	**118,962**

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

Dwellings £000	Assets under construction and POA £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000
–	–	–	–	–	–
388	24,775	1,176	-	4,414	928
388	24,775	1,176	-	4,414	928

ory education and training.

Dwellings £000	Assets under construction and POA £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000
389	7,550	2,549	93	3,248	3,638
389	7,550	2,549	93	3,248	3,638
–	13,760	820	–	2,096	147
			–		
			–		
–	–	–	–	–	–
–	(16,118)	–	–	–	–
–	–	–	–	–	–
(14)	–	–	–	–	–
–	–	(27)		–	–
375	**5,192**	**3,342**	**93**	**5,344**	**3,785**
23		1,782	93	1,779	2,230
23	–	1,782	93	1,779	2,230
20	–	172	–	644	339
–	–	–	–	–	–
(29)	–	–	–	–	–
–	–	–	–	–	–
–	–	–	–	–	–
(14)	–	–	–	–	–
–	–	(27)	–	–	–
–	**–**	**1,927**	**93**	**2,423**	**2,569**
366	7,550	700	–	1,469	1,408
–	–	67	–	–	–
366	**7,550**	**767**	**–**	**1,469**	**1,408**
375	5,192	1,361	–	2,921	1,216
–	–	54	–	–	–
375	**5,192**	**1,415**	**–**	**2,921**	**1,216**

rdance with IAS 16 - Property, plant and equipment. The values reported also include an element relating to the previous financial year.

charged on these assets in the year. These assets wholly relate to PFI assets.

Dwellings £000	Assets under construction and POA £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000
–	–	–	–	–	–
375	5,192	1,415	–	2,921	1,216
375	**5,192**	**1,415**	**–**	**2,921**	**1,216**

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

10.4 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 and fittings	5	10

10.5 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 January 2012 with an effective valuation date of March 31, 2012. Fair values were determined based on estimates. The impairment gains and loss recognised in the financial statements arose due to movement in market prices.

10.6 Non-current assets classified as held for sale

	March 31, 2012 £000	March 31, 2011 £000
Property, plant and equipment	580	–
TOTAL	**580**	**–**

The land at Rubery Hospital has been presented as held for sale following approval to dispose of the parcel of land by the board. It is expected that the sale will occur by September 2012. No loss or gain was recognised in operating expenses on reclassification to assets as held for sale.

11 Inventories

	March 31, 2012 £000	March 31, 2011 £000
Drugs	261	268
Materials	34	37
TOTAL inventories	**295**	**305**

11.1 Inventories recognised in expenses

	March 31, 2012 £000	March 31, 2011 £000
Inventories recognised in expenses	4,032	4,688
Write-down of inventories recognised as an expense	18	–
Reversal of any write down of inventories resulting in a reduction of recognised expenses	–	(17)
TOTAL inventories recognised in expenses	**4,050**	**4,671**

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

12 Trade and other receivables

	Total	Financial assets	Non-financial assets	Total	Financial assets	Non-financial assets
	March 31, 2012	March 31, 2012	March 31, 2012	March 31, 2011	March 31, 2011	March 31, 2011
	£000	£000	£000	£000	£000	£000
Current						
NHS Receivables	**2,791**	2,791	–	**3,430**	3,430	–
Other receivables with related parties	**4**	4	–	**5**	5	–
Provision for impaired receivables	**(698)**	(698)	–	**(1,395)**	(1,395)	–
Prepayments	**1,606**	–	1,606	**1,872**	–	1,872
PFI Prepayments						
Prepayments - Capital contributions	–	–	–	–	–	–
Prepayments - Lifecycle replacements	–	–	–	–	–	–
PDC receivable	**176**	–	176	**137**	–	137
Other receivables	**1,212**	717	495	**2,599**	1,963	636
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**5,091**	**2,814**	**2,277**	**6,648**	**4,003**	**2,645**
Non-current						
NHS receivables	–	–	–	–	–	–
Other receivables with related parties	–	–	–	4	4	–
Provision for impaired receivables	–	–	–	–	–	–
Prepayments	–	–	–	–	–	–
PFI Prepayments						
Prepayments - Capital contributions	–	–		–		–
Prepayments - Lifecycle replacements	**1,989**	–	1,989	**1,521**	–	1,521
Other receivables	–	–	–	–	–	–
TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES	**1,989**	–	**1,989**	**1,525**	**4**	**1,521**

12.1 Provision for impairment of receivables

Receivables are considered to be impaired when they are past their due date, the receivable has been outstanding for greater than 90 days and where management consider the receivable to be irrecoverable.

	March 31, 2012	March 31, 2011
	£000	£000
At April 1	1,395	1,068
Increase in provision	671	343
Amounts utilised	(1,006)	(16)
Unused amounts reversed	(362)	–
At March 31	**698**	**1,395**

12.2 Analysis of impaired receivables

	March 31, 2012	March 31, 2011
	£000	£000
Ageing of impaired receivables		
Up to three months	453	589
In three to six months	64	382
Over six months	181	1,072
TOTAL	**698**	**2,043**
Ageing of non-impaired receivables past their due date		
Up to three months	1,698	1,795
In three to six months	480	325
Over six months	289	88
TOTAL	**2,467**	**2,208**

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

13 Trade and other payables

	Total March 31, 2012 £000	Financial liabilities March 31, 2012 £000	Non-financial liabilities March 31, 2012 £000	Total March 31, 2011 £000	Financial liabilities March 31, 2011 £000	Non-financial liabilities March 31, 2011 £000
Current						
NHS payables	**3,018**	3,018	–	**4,023**	4,023	–
Amounts due to other related parties	**44**	44	–	–	–	–
Trade payables - capital	**3,642**	3,642	–	**1,360**	1,360	–
Other trade payables	–	–	–	–	–	–
Social security and taxes payable	**3,563**	–	3,563	**3,451**	–	3,451
Other payables	**5,958**	5,958	–	**8,826**	8,826	–
Accruals	**7,157**	7,157	–	**5,588**	5,588	–
PDC payable	–	–	–	**0**	–	0
TOTAL CURRENT TRADE AND OTHER PAYABLES	**23,382**	**19,819**	**3,563**	**23,248**	**19,797**	**3,451**
Non-current						
NHS payables	–	–	–	–	–	–
Trade payables - capital	–	–	–	–	–	–
Taxes payable	–	–	–	–	–	–
Other payables	–	–	–	–	–	–
Accruals	–	–	–	–	–	–
TOTAL NON CURRENT TRADE AND OTHER PAYABLES	–	–	–	–	–	–

Other payables above includes £1,249k (2010/11 £1,269k) in respect of outstanding employer pension contributions.

14 Other liabilities

	March 31, 2012 £000	As restated March 31, 2011 £000	April 1, 2011 £000
Current			
Deferred income	9,921	9,259	10,475
Deferred government grant	–	–	–
TOTAL OTHER CURRENT LIABILITIES	**9,921**	**9,259**	**10,475**
Non-current			
Deferred income	–	–	–
Deferred government grant	–	–	–
TOTAL OTHER NON CURRENT LIABILITIES	–	–	–

15 Borrowings

	March 31, 2012 £000	March 31, 2011 £000
Current		
Loans from Foundation Trust Financing Facility	760	–
Obligations under Private Finance Initiative contracts	1,560	1,720
TOTAL CURRENT BORROWINGS	**2,320**	**1,720**
Non-current		
Loans from Foundation Trust Financing Facility	39,432	19,169
Obligations under Private Finance Initiative contracts	62,896	64,478
TOTAL OTHER NON CURRENT LIABILITIES	**102,328**	**83,647**

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

16 Prudential borrowing limit

The NHS foundation 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, 2011). The trust had drawn down £nil of its working capital facility at March 31, 2012 (£nil March 31, 2011).

The trust has a prudential borrowing limit (PBL) of £129.9m in 2011/12 (£135.0m 2010/11). The trust has actually borrowed £104.6m as at March 31, 2012 (£85.4m at March 31, 2011).

16.1 Prudential borrowing limit ratios

Monitor has developed a tier two system which has been applied to the trust in calculating the PBL of £129.9m. 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 trust's 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, 2012	March 31, 2011
Minimum dividend cover	>1x	6.5	4.5
Minimum interest cover	>2x	3.9	3.4
Minimum debt service cover	>1.5x	2.9	2.3
Maximum debt service to revenue	<10%	3.0%	2.7%

The limit of £129.9m 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.

17 PFI obligations (on SoFP)

	March 31, 2012	March 31, 2011
Gross PFI liabilities	**£000**	**£000**
of which liabilities are due		
- not later than one year;	4,572	4,800
- later than one year and not later than five years;	17,520	18,011
- later than five years.	98,083	102,169
Finance charges allocated to future periods	(55,719)	(58,782)
Net PFI liabilities	**64,456**	**66,198**
- not later than one year;	1,560	1,720
- later than one year and not later than five years;	6,182	6,393
- later than five years.	56,714	58,085
TOTAL	**64,456**	**66,198**

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

17.1 PFI obligations

The trust is committed to make the following payments for on SoFP PFIs obligations during the next year in which the commitment expires:

	March 31, 2012 Total £000	March 31, 2012 PFI 1 £000	March 31, 2012 PFI 2 £000	March 31, 2011 Total £000
21st to 25th years (inclusive)	**3,018**	3,018	-	-
26th to 30th years (inclusive)	-	-	-	2,876
31st to 35th years (inclusive)	**6,383**	-	6,383	-
36th year and beyond	-	-	-	6,025

17.2 PFI commitments (on SoFP)	March 31, 2012 £000	March 31, 2011 £000
Commitments in respect of the service element of the PFI		
- not later than one year;	9,401	8,901
- later than one year and not later than five years;	40,011	37,988
- later than five years.	394,882	394,171
	444,294	**441,060**
Present value of commitments		
- not later than one year;	8,938	8,463
- later than one year and not later than five years;	33,585	31,885
- later than five years.	167,542	163,380
TOTAL	**210,065**	**203,728**

17.2 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 Taskforce 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 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 annual movement in RPIx but are subject to a market testing exercise which takes place every five 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 Taskforce 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.

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

18 Provisions for liabilities and charges	**Total**	**Legal claims**	**Property**	**Restructuring**	**Injury Allowance**	**Other**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
At April 1, 2011	**4,717**	**289**	**1,037**	**2,771**	**238**	**382**
Arising during the year	**2,112**	397	186	1,529		
Utilised during the year	(2,005)	(251)	(103)	(1,581)	(60)	(10)
Reversed unused	**(1,443)**	(60)	(193)	(1,190)		
Unwinding of discount	–					
At March 31, 2012	**3,381**	**375**	**927**	**1,529**	**178**	**372**
Expected timing of cash flows:						
- not later than one year;	**2,645**	375	336	1,529	33	372
- later than one year and not later than five years;	**228**	–	151	–	77	–
- later than five years.	**508**	–	440	–	68	–
TOTAL	**3,381**	**375**	**927**	**1,529**	**178**	**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 within 2012/13.The trust has £99k (2010/11 £80k) of contingent liabilities in respect of legal claims.

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 in 2012/13.

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 all claims will be received in 2012/13.

18.1 Clinical negligence liabilities	**March 31, 2012**	**March 31, 2011**
	£000	**£000**
Amount included in provisions of the NHSLA in respect of clinical negligence liabilities of Birmingham and Solihull Mental Health NHS Foundation Trust	594	1,045

19 Contractual capital commitments

The trust was contractually committed to £10,099k (£26,684k at March 31, 2011) of capital expenditure for the purchase of property, plant and equipment.

20 Third party assets

The trust held £844k cash and cash equivalents at March 31, 2012 (£812k March 31, 2011) 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.

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

21 Cash and cash equivalents

	March 31, 2012 £000	March 31, 2011 £000
At April 1	33,613	32,097
Net change in year	1,847	1,516
At March 31	**35,460**	**33,613**
Broken down into:		
Cash at commercial banks and in hand	39	43
Cash at OPG (Office of Paymaster General)	35,421	33,570
Cash and cash equivalents as in SoFP	**35,460**	**33,613**
Bank overdraft	–	–
Cash and cash equivalents as in SoCF	**35,460**	**33,613**

22 Ultimate parent company

The foundation trust is a public benefit corporation established under the NHS Act 2006. Monitor, the NHS Foundation Trust Regulator has the power to control the foundation trust within the meaning of IAS 27 'Consolidated and Separate Financial Statements' and therefore can be considered as the foundation trust's parent. Monitor does not prepare group accounts but does prepare separate NHS Foundation Trust Consolidated Accounts. The NHS FT Consolidated Accounts are then included within the Whole of Government Accounts. Monitor is accountable to the Secretary of State for Health. The foundation trust's ultimate parent is therefore HM Government.

22.1 Related party transactions

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:

	2011/12 £000	2010/11 £000
University Hospital Birmingham NHS Foundation Trust	1,615	1,944
London Strategic Health Authority	6,746	6,649
West Midlands Strategic Health Authority	7,160	6,831
Birmingham East and North PCT	161,644	161,332
Heart of Birmingham Teaching PCT	17,540	16,532
Sandwell PCT	1,303	1,672
Solihull Care Trust	15,401	16,090
South Birmingham PCT	217	4,520

	Expenditure >£1.5m 2011/12 £000	2010/11 £000
Birmingham Community Healthcare NHS Trust	3,254	3,350
Heart of England NHS Foundation Trust	1,666	2,263
Prescription Pricing Authority	3,470	2,628
Birmingham City Council	3,250	1,063
South Birmingham PCT	83	2,974

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

22.2 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, 2012	**March 31, 2011**
	£000	**£000**
University Hospital Birmingham NHS Foundation Trust	281	1,072
Birmingham East and North PCT	418	1,117
Birmingham City Council	281	1,020

	Payables > £0.5m	
	March 31, 2012	**March 31, 2011**
	£000	**£000**
Heart of England NHS Foundation Trust	1,677	1,345
NHS Business Services Authority	640	741
Birmingham City Council	928	–

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 the year end the trust was owed £36k (2010/11 £19k) from the charity for expenses incurred by the trust related to the charity.

In addition to these balances the trust was owed £4k (2010 £9k) from a director, 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.

22.3 Key management personnel

	2011/12	**2010/11**
	£000	**£000**
Salaries and other short term benefits	933	853
Termination benefits	–	–
Total	**1,034**	**947**

Key management personnel are considered to be the executive and non-executive directors of the trust.

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

23 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS trust has with primary care trusts and the way those primary care trusts are financed, the NHS trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS trust has limited powers to borrow or invest surplus funds and financial assets 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 as confirmed by the Strategic Health Authority. The borrowings are for one to 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, 2012 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 primary care trusts, which are financed from resources voted annually by Parliament. The trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The trust is not, therefore, exposed to significant liquidity risks.

24 Financial assets by category

	March 31, 2012		March 31, 2011	
	Total	Loans and receivables	Total	Loans and receivables
	£000	£000	£000	£000
Assets as per SoFP				
Trade and other receivables excluding non financial assets	**2,814**	2,814	**4,007**	4,007
Cash and cash equivalents (at bank and in hand	**35,460**	35,460	**33,613**	33,613
TOTAL AT MARCH 31	**38,274**	**38,274**	**37,620**	**37,620**

25 Financial liabilities by category

	March 31, 2012		March 31, 2011	
	Total	Other financial liabilities	Total	Other financial liabilities
	£000	£000	£000	£000
Liabilities as per SoFP				
Borrowings excluding finance lease and PFI liabilities	**40,192**	40,192	**19,169**	19,169
Obligations under Private Finance Initiative contracts	**64,456**	64,456	**66,198**	66,198
Trade and other payables excluding non financial assets	**19,819**	19,819	**19,797**	19,797
TOTAL AT MARCH 31	**124,467**	**124,467**	**105,164**	**105,164**

26 Losses and special payments

NHS foundation trusts are required to report to the Department of Health any losses or special payments, as The department still retains responsibility for reporting these to Parliament.

There were 165 cases of losses and special payments totalling £1.2m during the year to March 31, 2011 (118 cases totalling £103k during year to March 31, 2011). These amounts are reported on an accruals basis but excluding provisions for future losses. The current year includes a specific write off of debt of £0.8m which was fully provided against in previous years.

Birmingham and Solihull Mental Health NHS Foundation Trust – March 31, 2012

Notes to the financial statements

27 Pensions

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) 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
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at March 31, 2012, is based on detailed membership data as at March 31, 2010 updated to March 31, 2012 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions
The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the scheme or the specific conditions that must be met before these benefits can be obtained:
The scheme is a final salary scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the scheme regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.
With effect from 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 12 months ending September 30 in the previous calendar year. From 2011/12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVCs run by the scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

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