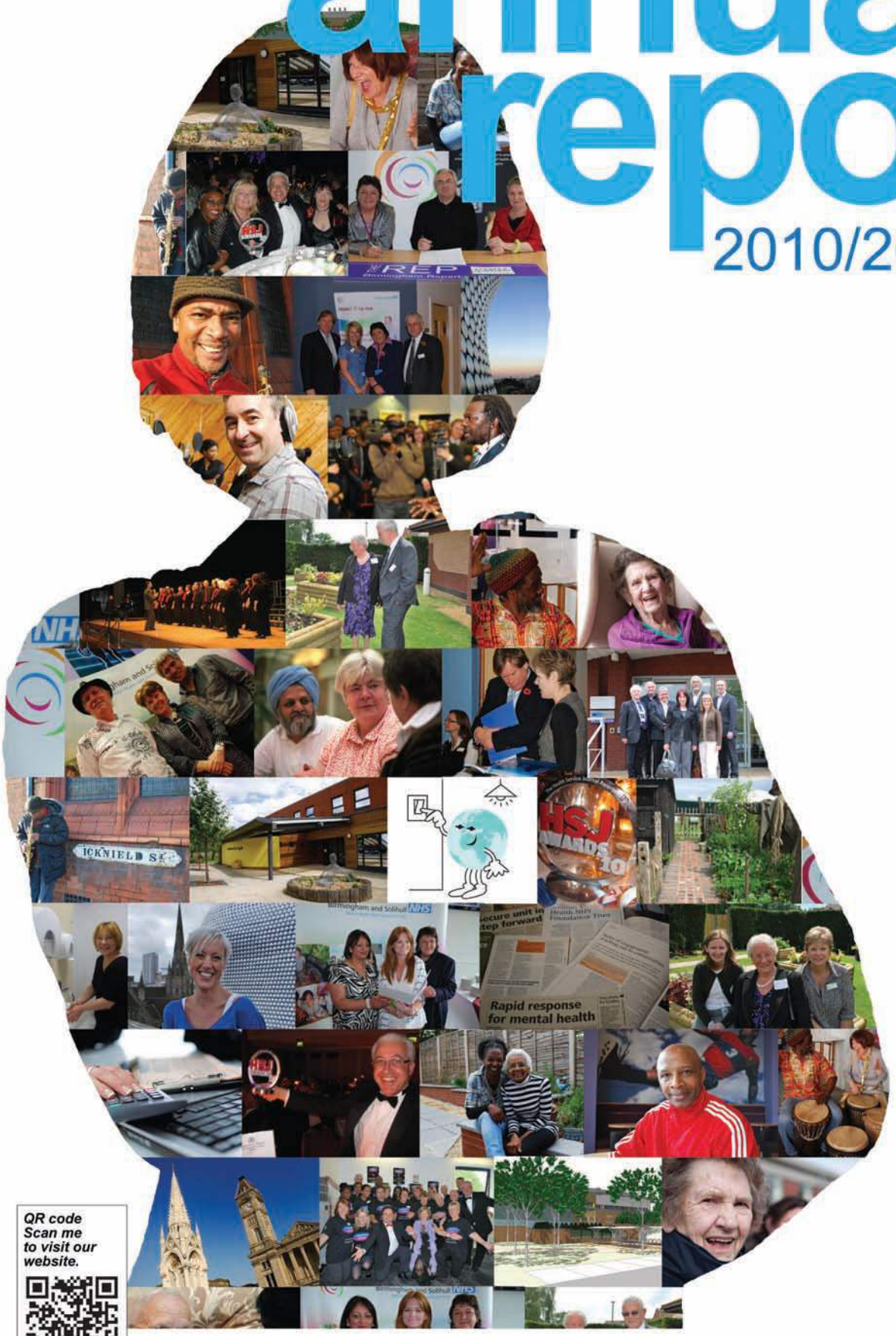
Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

annual report

2010/2011



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getting better together

Birmingham and Solihull Mental Health NHS Foundation Trust
Annual Report and Accounts 2010/11

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

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, 2010 to March 31, 2011.

Throughout the period, we have continued to demonstrate our commitment to making sure people with mental health problems receive swift and appropriate treatment in the best possible setting to suit their needs.

During 2010 our commitment to investing in services continued as construction work on the Juniper Centre – a new £17.7m development for our Mental Health for Older People Services division – in Moseley, was completed. Staff and patients moved into their new 'home', in the grounds of Moseley Hall Hospital, in December 2010.

BSMHFT also managed to secure extra funding for its award-winning Rapid Assessment Interface and Discharge (RAID) service, to enable the psychiatric liaison service – based at City Hospital in Winson Green – to continue through 2011/12.

Furthermore, a number of our staff and services were recognised this year as our trust won a clutch of national and regional awards for its achievements and excellence.

Green-fingered staff and service users from the trust's allotment project celebrated success at the Malvern Spring Gardening Show in May, where their Recovery and Wellbeing Garden scooped a gold medal – and praise from Princess Anne who visited their winning cottage garden.

Stars including actress Patsy Palmer and poet Benjamin Zephaniah supported the trust's launch of The Revolving Door, a film which challenges the stigma that surrounds mental health issues. The short film, written and produced by Birmingham-based writers Dan Wilson and Shaun Welch, was premiered at an event at Aston Villa Football Club in May, attended by more than 400 people.

On a smaller scale, the Birmingham Memory Assessment and Advisory Service, run by our trust, also produced a DVD - Dementia Aur Aap, filmed in Hindi and subtitled in English - aimed at raising awareness of dementia within the local Asian community during Dementia Awareness Week in July.

In October, our trust took the first step in cementing its first international partnership with the Bermuda Hospitals Board, to support and provide forensic mental health services in Bermuda. A statement of intent was signed by our chief executive, Sue Turner, and Bermuda's Minister for Health, Walter Roban, which will see the organisations work together on both sides of the Atlantic to help service users in acute and community settings.

Our trust joined forces with the national Time To Change campaign in October to stage the Time To Get Moving: Birmingham event in Cannon Hill Park, Edgbaston, on World Mental Health Day.

Health Minister Simon Burns was impressed by our trust's initiatives to improve patient experience and dignity, during a visit to our Barberry and Oleaster centres in November.

During the visit he took part in a discussion with staff and service users about patient experience, and also met members of our Rapid Assessment, Interface and Discharge (RAID) team to learn about their pioneering service, delivered in partnership with colleagues at City Hospital, in Winson Green.

Weeks after that visit, the RAID team won a prestigious Health Service Journal Award for mental health

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

innovation at a ceremony in London.

The Juniper Centre in Moseley – Birmingham's new national centre for older people's mental health services – opened its doors to staff and service users for the first time in December.

The £17.7m development, a specialist centre within the grounds of Moseley Hall Hospital, brings together stroke services, rehabilitation, and diagnostic facilities for physical and mental health services onto the same site.

In the new year our trust signed another agreement to share its expertise with Staffordshire University, particularly their Centre for Ageing. Chief executive Sue Turner and the university dean Hilary Jones, signed a memorandum of understanding in March.

Our trust continued to pick up top awards, with its innovative approach to reducing violence at Ardenleigh, a forensic unit for child and adolescent mental health services in Erdington, winning a Nursing Times/Health Service Journal Patient Safety Award for patient safety in mental health.

However, despite our successes we must not become complacent and acknowledge that the coming years will bring a host of new challenges.

Following the publication of the Health and Social Care Bill in February, it is clear the NHS landscape is set change, and trusts are facing difficult choices over how they use their budgets.

We have continued to make bold investments to improve our facilities, such as the new Yardley Green 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 increase our membership base. During 2010/11 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 13,677 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 in 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.

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

Peter Marquis
Chairman

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, 2010 to March 31, 2011 for the financial year 2010/11.

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 more than 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

Getting better together. That's our mission statement, pure and simple.

We want to help people get better and create a service we are all happy to recommend to others.

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 (sub-contracting 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;
  b) appropriate housing (independent and supported).

The RAID Service's glittering prize.

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, Secure and Complex Care (YASSC); Mental Health Services for Older People (MHSOP), 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 plan of care which suits each individual person and offers different types of support including community, inpatient, outpatient and day services.

We have worked, and will continue to work, hard to support and improve the mental health of people across our patch through a range of locally based inpatient and community services.

We 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

There is no doubt that 2010/11 was a very successful year for BSMHFT, with staff across our trust winning awards for innovative and successful approaches to care, sustainability and even gardening.

In May, a team of green-fingered staff and 21 service users from the trust's allotment project scooped a gold medal – and praise from Princess Anne, who visited their award-winning garden at the Malvern Spring Gardening Show.

The Recovery and Wellbeing garden was one of just two gardens at the Three Counties Showground in Malvern to receive a gold medal.

Dougal Philip, chairman of Shows Advisory Committee, said: "This cottage garden was just perfect, we could find no fault with it at all, and the attention to detail was awe-inspiring."

Designed to promote the allotment project, the garden featured a path paved with 150 terracotta tiles, handmade by service users, chickens and a scarecrow, as well as seasonal plants.

In November, the trust's Rapid Assessment, Interface and Discharge (RAID) service, which provides a gateway to mental health services via A&E at City Hospital, in Winson Green, won a prestigious Health Service Journal Award for mental health innovation.

Launched in December 2009, RAID's specialist team work closely with medics at City Hospital and the charity Aquarius to provide a 24-hour service, ensuring patients with mental health, alcohol or drugs problems are assessed and treated much earlier.

Not only has this resulted in better patient care, it has also led to significant savings and avoided unnecessary admissions onto busy

medical wards at City Hospital.

The trust hopes to roll out the RAID service model to other hospitals in Birmingham and beyond, as it has the potential to save millions of pounds for the NHS.

In March, the trust's innovative approach to reducing violence at one of its inpatient units was recognised at the Health Service Journal/Nursing Times' Patient Safety Awards.

Staff at Ardenleigh – a forensic unit for child and adolescent mental health services – have worked with West Midlands Police and the Crown Prosecution Service to tackle challenging and violent behaviour on specialist ward in Erdington, Birmingham.

This initiative, which promotes patient, staff and public safety at Ardenleigh, beat six other NHS trusts in the patient safety in mental health category.

Pc Karen Burnham, a liaison officer with West Midlands Police, works with young service users through mediation to resolve issues before they escalate further.

Pc Burnham said: "Ardenleigh is a community and this project has provided a way, through partnership working, to achieve what previously had been thought impossible. All partners have seen improvements since this project was launched in 2009, especially the staff and the young people at this unit."

In the spotlight

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

As a summary, Birmingham and Solihull Mental Health NHS Foundation Trust featured in 15 press and magazine articles. Of these 10 were in local newspapers, four were in specialist publications, and one in a national newspaper.

April and May were quiet due to the constraints of purdah, in the run up to the general election and local council elections in May.

Andy Gayle is one of the trusts good news stories this year.

However, the trust's success at the Malvern Spring Gardening Show, where our Recovery and Wellbeing Garden received a gold medal and a visit from the Princess Royal, was reported in the *Malvern Gazette*.

In June, the *Birmingham Mail* carried a positive piece on actress Patsy Palmer who spoke to delegates about her personal fight against depression and addiction at the trust's screening of Revolving Door at Villa Park.

Two stories appeared in the *Press Gazette* and the *New Statesman* in August, following a Press Complaints Commission ruling into stories run the *Birmingham Mail* and *Birmingham Post* in February and March 2010 concerning the closure of personality disorder service at Main House in Northfield. Following the trust's complaints about intrusion into patients' grief and shock by using pixellated photos of service users receiving the news, the PCC took the decision that the story was in the public's interest, and supported the paper's decision to publish the story and photos.

In October, our medical director Peter Lewis was approached by the *Birmingham Mail* to provide an expert view on what people should do if they believe a friend or relative is having suicidal thoughts. This followed a two-day standoff between police and a man threatening to jump from a bridge in Birmingham, which resulted in key city centre routes being closed for 30 hours.

The following month, stories appeared in the Solihull press regarding the reorganisation of mental health services in the borough *(Solihull News)* and a woman who absconded from an ward at Solihull Hospital to stage a rooftop protest in the Mell Square Shopping Centre (*Solihull News* and *Solihull Observer*). The tone of all three was negative.

In the run up to Christmas, as public sector cuts loomed large over the media, the *Birmingham Mail* ran a front page splash on the number of nurses' jobs likely to go across NHS trusts in the Midlands. BSMHFT was among those named, but it did not focus on the trust specifically.

February was a mix of good and bad news, with one of our service users Andy Gayle making headlines with his music in both the *Birmingham Mail* and *The Voice,* which published really positive stories about him and his music. However this was tempered by the *Health Service Journal,* who printed two stories based on comments made during recent board meetings. The tone was financial rather than negative.

Finally, in March, our awards success was recognised by the *Birmingham Mail.* A short piece about staff at Ardeneligh winning a Nursing Times/HSJ Patient Safety Award, followed by a larger story about the Rapid Assessment, Intervention and Discharge (RAID) service which was 'at risk' as commissioners tried to fund the service, which won a HSJ Award for innovation in mental health in December. The tone was positive about the service, but negative towards commissioners.

patient care

New services for patients

The Juniper Centre

In 2008/9 our trust opened the Barberry, Oleaster and Zinnia centres as part of the National Centre for Mental Health: Birmingham. Now, the £17.7m Juniper Centre for older people's services - built on the Moseley Hall Hospital site in south Birmingham - is the fourth centre to open under this scheme.

Work has progressed rapidly since 2009; and staff donned their hard hats and wellies to get a first look at their new workplace on an exclusive tour, prior to completion of the build, in March 2010.

This purpose-built, specialist centre brings together acute services and diagnostic facilities for managing physical and mental health issues on the same site, enabling staff to offer patients the best possible care and support to their carers and families.

Spread over two floors, the new hospital houses three suites – Bergamot, Rosemary and Sage – each with 18 single en-suite rooms. It also has a café, therapy suite, outpatients department, education suite and a therapeutic garden. This state of the art building includes environmentally friendly design, ground source heating systems, solar powered ventilation and sun pipe lighting. Our development plans included the planting of new trees and shrubs around the site to replace those that we have had to remove due to their poor condition.

This centre of excellence is a unique development because it is co-located with existing services at Moseley Hall, provided by Birmingham Community Healthcare NHS Trust. This creates a specialist centre which brings together stroke services, rehabilitation and diagnostic facilities for managing physical health and mental health services for older people together on the same site.

Interserve, our contractors and partners in this project, handed over the new building to the trust in November 2010. Staff and patients moved in early December, and the hospital is now fully operational

Improvements in patient care information

Our trust is committed to the experiences and views of people who use our services and facilities. Because of this, a new project is currently underway looking at the process of patient feedback and, more importantly, how this feedback is utilised to improve our services.

To complement the existing channels of gathering service user, staff and carer views, our trust is investing in new technologies such as handheld tablet PCs, personal digital assistants and kiosks.

This will ensure that patients have a method of giving feedback that is tailored to their needs and preferences, although this project is much more than simply gathering the views of services. It takes a look at the whole process of feedback, and is putting in place structured processes with which the trust can analyse and act upon the information it has received, ultimately reporting back to our service users, staff and carers, and demonstrating exactly how their feedback has shaped our services.

Throughout the pilot project, the team have worked closely with six different sites within our trust, speaking to service users, carers and staff, and listening to what they feel would work for them. Not only will these key stakeholders involved from the very beginning in shaping the project, but will also be invited to vote on the name of this initiative.

Patient Advice and Liaison Service (PALS)

Our Patient Advice and Liaison team had one of their busiest years ever. In addition to dealing with up to 1,000 calls for support every month they have also been implementing a network of drop-in surgeries to gain even closer access to patients.

This has been especially important in some of our secure services and PALS are delighted to have consolidated their visits to Reaside and Ardenleigh while launching new services to HMP Birmingham prison.

Through analysis of call rates PALS have now focused their core hours on the 8am to 8pm period, Mondays to Fridays. This is when they receive the vast majority of phone calls, and when they can maximise access to patients, users and carers. The team now visit all inpatient areas monthly, plus many community sites, user groups and carer groups.

PALS also works in partnership with other agencies to bring better advice to patients. A new series of seminars in welfare rights and debt advice are being provided through working with Building Community Advocacy.

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 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 we 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 updated our patient information leaflets and worked to produce some of these in an Easy Read format to assist our users with learning disabilities or poorer concentration. We have also enhanced the information on our trust website and created links to the respected Choice and Medication site, where users, carers and public can compare psychiatric medications and side effects.

We are increasingly using patient and carer stories in our training and service improvement events. These are vital to capture the patient pathway and our staff have found them enlightening, and appreciate the gritty nature of the way these stories are told.

We have needed to involve our service users and carers in a number of crucial consultations this year, including changes to PALS hours and the future of day services. It is important to ensure that everyone has the opportunity to be involved in important debates about the future shape of our health services.

Real time patient feedback

We are rolling out a large scale pilot of the successful real time feedback work undertaken by this trust. We are seeking to receive feedback far more regularly than ever before. This feedback is automatically collated and analysed enabling us to make swift improvements in our services which can be demonstrated to users, carers, the public and our commissioners.

Through looking at the work of other NHS trusts we are convinced that our partnership with Fr3dom health will lead to big improvements in service delivery and enable patients, users and carers to be more involved than ever before. An important element is the design of the questions which relies on input from corporate staff, the local staff team and service users equally.

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

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 complaints department can be contacted.

Our complaints department 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.

Complaints received by the department 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, 2009 and March 31, 2010 – 302 out of 344 (88 per cent) were answered within the agreed timescale.

The Learning Lessons and Trend Analysis Group works to ensure that improvements resulting from complaints are implemented and will monitor any actions identified.

For more information about the complaints department or the trust's complaints procedure please contact the complaints team on 0121 301 2000 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 fourth 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 chairman.

Improvements in 2010/11 included:

- Ordering of new staff badges and welcome boards (numerous trust sites)
- Telephone call handling training (Ladywood Health Centre/Small Heath)
- PALS displays: General advice and nutrition/fitness (Riverside and Northcroft)
- Improvements to poster boards (Soho Hill, Mary Seacole and Longbridge)
- Improved cleaning schedules (Phoenix Day Centre and Soho Hill)
- Better management of blue badge parking spaces (Oleaster and Longbridge)
- Improved signage and external tidiness (Ladywood Day Centre)
- Circulation of poster promoting availability of leaflets in other languages (numerous trust sites)
- Improved pedestrian access in conjunction with University Hospital Birmingham and Balfour Beatty (Barberry)
- New drinking water fountains with direct mains flow (numerous sites).

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.

The trust the following priorities with local commissioners:

- *Progress and delivery of HONOS Payment by Results implementation:* This required improved performance against the previous year. The target was to ensure that 75 per cent of the current caseload had been allocated to a care cluster and this was achieved. The Health of the Nation Outcome Scale (HONOS) is a standard measurement tool used by mental health services. This is completed as part of reviewing the needs of individual patients enabling clinicians to allocate referrals to appropriate care pathways and treatment plans. The HONOS process is one that is being taken forward on a national basis.
- *Reducing length of stay where appropriate for acute inpatients:* This is a specific programme of work agreed with Birmingham commissioners to work with our partners to ensure that service users who do not need to be in hospital are appropriately discharged with the relevant support and care package being in place. Good progress has been made in the last year.
- *Development of a dementia pathway* with our partners to ensure that the referral, assessment and treatment pathway is clearly set out and agreed with our partners. In addition we have trained staff across all services so that they can recognise and support our service users better.
- *Surveying our service users to understand their views on our services and where we can make improvements.* Through repeating the survey at the end of year we were able to demonstrate improvements in feedback.
- *Understanding how long young people wait to access our services from when they become unwell.* Through the work we now understand the length of time and are able to implement actions to reduce this through working with other services and GPs.
- *Ensuring we record the accommodation and employment status of our service users and demonstrate that we act on any concerns and provide appropriate support.*

Infection prevention and control

The Infection, Prevention and Control (IPC) team have continued to work closely with colleagues in estates and facilities. The number of infections reported has reduced and there have been no outbreaks of infections this year.

The IPC team and estates and facilities were finalists in the HSJ/Nursing Times Patient Safety Awards in March 2011, for their Strictly Come Cleaning campaign, which promoted the trust's new cleaning strategy.

An information leaflet has been compiled for service users and carers called Infection prevention and control within the healthcare environment.

The team have undertaken 30 environmental audits, concentrating on the community units. The trust's decontamination officer has continued to undertake audits on reusable medical devices across the trust's sites. Kitchen inspections have been carried out by the hygiene advisor across production, ward and training kitchens.

Hand hygiene at the point of care has been the focus of this year's training.

Sharon Duffy demonstrates handwashing technique.

Alcohol gels following a National Patient Safety Agency alert have been removed from entrance to wards, however all staff should have access to individual alcohol gels to be able to perform hand hygiene at the point of care. Most areas of the trust have hand hygiene trainers who can deliver best practise hand hygiene training within the work place.

Infection Prevention Week was promoted by the IPC team and supported across all three trust divisions. Two competitions were well received and the winning individuals/teams were celebrated within the trust's news channels.

Pat Wain, a Care Quality Commission (CQC) adviser was invited by the IPC team to deliver a workshop for the trust, highlighting key themes. This was followed by two informal mock inspections at trust sites with prior agreement to give an indication of what staff may expect. The IPC team then facilitated attendance at management meetings by invite to reiterate CQC standards/ expectations.

Infection control training is delivered at induction for all new staff to the trust. It is also delivered at the statutory and mandatory, clinical and non-clinical training days. Food hygiene awareness along with infection control is delivered at both the road shows and the statutory and mandatory days for clinicians. Infection control link workers training days have been held quarterly which enable the LINk workers to support ward managers and matrons with infection control practice and awareness in their area. Food safety level 2 training continues to be a delivered to staff who carry out food preparation of supervise service users preparing food.

Learning lessons

Ensuring improvements result as a result of incidents, staff experience and feedback from service users is a significant element of our clinical governance processes (how we ensure quality improvement).

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

A number of policies have been introduced to reinforce best practice, these include:

- Management of serious Incidents requiring investigation
- Being Open policy
- Clinical supervision
- Rapid tranquilisation
- Medicines reconciliation

Changes have been made to existing policies and documentation:

- Referrals management
- Lone working
- Food and nutrition
- Decontamination
- Corporate records management

In other issues policies have been reinforced where non-compliance has been identified:

- Transition and transfer (care management)
- Medicines code
- Care records management

Improvements in how we manage risk

The trust has made improvements to further improve feedback to staff on incidents. Over 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.

Information is now published monthly on the intranet for any member of staff to be able to review any trends or details of incidents which have arisen in a particular location or time period.

By openly sharing this information staff are further supported to address concerns and reassured of the positive benefits of incident reporting.

Looking to the future

This year our trust has improved and evolved to provide care, facilities and services fit for purpose in the 21st century.

Our trust will continue to develop and grow its business, based on both strategic objectives and the needs of the communities we serve.

Wherever possible, our developments will be made in partnership and after engagement with our service users, carers and members.

We will continue to provide services which are at the very forefront of modern mental health care over the coming years, which will include some of the following schemes.

Yardley Green Medium Secure Unit

Our plans to open a new medium secure unit for men in east Birmingham have progressed significantly since last year.

After the Department of Health agreed the funding for our new hospital site, located on Yardley Green Road, Bordesley Green, with full planning permission also in place we have now begun building this new hospital.

This 89-bed medium secure unit for men in east Birmingham have progressed since last year and based on current plans, the new facility should open during autumn 2012.

Interserve are the main contractors building the hospital, and work began February 2011.

Our trust is implementing a robust community engagement and communications strategy to accompany the build, ensuring all of our stakeholders and local communities are kept up to date with developments.

A series of community engagement events are planned throughout 2011/12 to keep local residents and businesses informed about the development and the career opportunities it will bring to the area.

innovations and partnerships in mental health

Our trust prides itself on pioneering innovative interventions, and 2010/11 resulted in a bumper crop of new services – many of which were devised and delivered in partnership with other NHS providers, third sector organisations and private sector partners.

Solihull Integrated Addiction Services – which brings together our trust's award-winning substance misuse service based at The Bridge in Chelmsley Wood, with Aquarius, Welcome, Str8 Up and the government's Drug Intervention Programme – which provides a one-stop shop for people with drug or alcohol problems.

Last year the trust signed a pioneering reciprocal agreement with the Bermuda Hospitals Board to provide services and train staff, in its first international partnership.

The innovations listed below all illustrate how productive such partnerships can be.

Rapid Assessment, Interface and Discharge (RAID) Service

Our Rapid Assessment, Interface and Discharge (RAID) model, which is the first of its kind in the UK, ensures patients get help for mental and physical health at the same time – delivering all the care that people need, when they need it – in one of Birmingham's busiest acute hospitals.

The government's new 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. Sir David Nicholson, the NHS's chief executive, has highlighted the importance of treating both physical and mental healthcare as one of the ways to make the biggest impact on both improving quality and saving money.

Recent research highlights how important it is for acute hospitals to address the needs of patients who self harm or misuse substances, recognise the impact of conditions like depression and dementia, and those who present as complex cases with both physical and mental illness, which often result in repeat admissions to acute care.

RAID is a great example of how this new strategy works in Birmingham. Our specialist team assesses and treats patients aged over 16, who present at A&E or are already inpatients at

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

Birmingham's City Hospital, getting them the help they need, regardless of age, locality, complaint, severity or time of presentation.

This award-winning service – which was launched at City Hospital in December 2009 and receives around 250 referrals a month – is accredited the Royal College of Psychiatry's Psychiatric Liaison Accreditation Network.

In November 2010, less than a year after the service was launched, our RAID team won the prestigious Health Service Journal Award for innovation in mental health.

Reeds – service user artwork, Phoenix Centre art group.

On the right path

The key to RAID's unique model is to see everyone referred from A&E within an hour, and all others within 24 hours. This means care for people with mental health problems is initiated early and problems are dealt with swiftly.

There are many different types of mental health problems, with RAID whatever the problem, the team can assess patients and initiate the treatment they may need. Staff in the RAID team provide tailored interventions, signposting, follow-up clinic appointments and onward referrals to GPs, Aquarius and third sector organisations that have been set up to provide on-going help in the community.

Staff at City Hospital also received training on mental health awareness and interventions. Staff reported this was highly relevant and has led to improvements in their practice, which in turn improves patient experience, with better detection, diagnosis and therefore earlier treatment.

The most common reasons for referral to RAID were deliberate self harm, depression, confusion/dementia, alcohol misuse, suicidal thoughts, and psychosis.

Patient experience

Before RAID was introduced at City Hospital, patients who presented to A&E or on one of their inpatient wards with a mental health difficulty had to wait to be referred to our trust for assessment, before they could be put on the appropriate care pathway. This created delays and the patient experience could become disjointed and frustrating.

Now when a patient arrives at the hospital, the RAID team are alerted to provide an assessment prior to admission. The RAID model has shown clear benefits in service delivery, increasing staff and patient satisfaction, rapid response times and delivering high cost savings while improving the overall quality of care.

Discharge and support in the community

RAID's primary aim was to streamline the patient journey. In achieving this aim, RAID has also had a beneficial effect on traditional winter pressures, by reducing length of stay and the number of readmissions.

A sample study conducted by the RAID team revealed that patients seen by our service were discharged quicker than those who were not seen by a member of the team – with 75 per cent discharged within a week, and 65 per cent within three days, of seeing RAID. This prevented unnecessary long stays in hospital, enabling safe and early discharge.

The number of older adults seen by RAID, who had come from their own home and returned there, almost doubled with 80 per cent returning home compared to 47 per cent pre-RAID.

Our specialists in working with older people with mental health problems, who are embedded in the acute hospital through RAID, can support other professionals to jointly manage the potential risks of discharge and facilitate rapid access to specialist community support.

Avoiding acute hospital admissions – and saving money

To assess the financial impact of our RAID model at City Hospital, data on three key areas was independently collected and analysed to identify cost savings. This information focused on reduced length of stay, reduced readmissions and admission avoidance at the medical assessment unit (MAU).

Length of stay: RAID saved 21,509 bed days over 12 months (58.9 beds per day), with an associated cost saving of around £4.5 million.

Reduced readmissions: RAID saved 1,800 admissions over 12 months, saving approximately £5.4 million. This amounts to 8,100 saved bed days (22 beds per day).

Admission avoidance: By avoiding admissions at the point of MAU, RAID saved £454,500 through 202 patients receiving a reduced tariff of £750, rather than the £3,000 an admission would have cost.

In total, the combined savings are estimated at £10 million (ranging between £7 million and £12 million).

RAID's innovative model has shown it is possible to improve patient experience and quality of care while delivering significant cost savings within the service.

Research and innovation

Our research and innovation team, based at Radclyffe House in Edgbaston, are pioneering new ways of working and delivering better care across our trust.

As the NHS has had to embrace numerous changes in recent years, so our trust's research team have had to adapt, as the NHS moves towards a more outcome-focused approach to delivering services.

One of the team's key projects began in 2010/11, a five-year study aimed at cut waiting times for treatment for young people experience serious mental health problems, such as psychosis. At present, the delay between onset of symptoms and effective treatment faced by young people is about 12 months, but experts in this field, within our trust, aim to reduce this to just three months.

Professor Max Birchwood, who is the trust's director of Birmingham Early Intervention Services and director of research and innovation, is leading the project to reduce waiting times for treatment during the 'critical phase' after diagnosis.

He said: "The average age for diagnosis of psychosis is 21. In Birmingham and elsewhere there's a delay of about a year from the onset of symptoms to someone getting effective treatment.

"It's this delay that is really crucial. Like with cancer: the longer you leave it, even after treatment, the more likely there are to be residual symptoms a year or two later."

The study is being funded by a £1.1 million grant through the National Institute for Health Research (NIHR) Collaborations for Leadership in Applied Health Research and Care for Birmingham and Black Country.

Alongside this is the SUPEREDEN research programme, also funded by the NIHR for £2 million over five years. This series of studies aims to target those who have experienced Early Intervention Services (EIS) throughout the UK and will assess the following:

- the full impact of EIS over three years in routine settings,
- different illness trajectories seen under EIS, and
- the ideal form of care needed to maintain gains following discharge.

Our trust has also opened a new clinical trials facility at its Northcroft site in Erdington – to complement the existing lab at the Barberry, in Edgbaston - which is attracting interest from private-sector pharmaceutical firms, both in clinical work and industry support.

This yet another example of how the trust is developing partnerships across various sectors, while also fulfilling the government's aim to increase NHS work with industry.

In March, research and innovation staff came together to showcase their work at a special event staged at the Centennial Centre in Ladywood.

This gave the team a chance to promote their achievements within the department, which has been praised both nationally and internationally for its work.

Funding for research has increased over the past few years, emphasising its significance in the treatment and care of service users.

Prof Birchwood, said: "Research is a crucial part of the trust. It helps us to develop and market effective and high quality services.

"With the changes in the way the NHS will deliver its services in the future, quality and innovation will be high on the agenda and the trust is in a strong position to deliver this well."

Strictly Come Cleaning

Our trust also used an innovative approach to launch its strategic cleaning plan in May.

Strictly Come Cleaning injected a bit of fun into a serious message, to encourage staff to ensure their workplaces and wards were spotless.

Staff from infection prevention and control, estates and facilities, aided by colleagues from Amey Community Limited – the trust's PFI contract provider – donned their best gloves, frocks and tiaras to bring some glamour

The trust's Strictly Come Cleaning celebrate their award success.

to their daily cleaning routine.

A trustwide competition was held during May to highlight he importance of cleanliness on all of sites, but also to recognise the valuable service domestic staff and housekeepers provide.

Throughout the campaign staff wore Strictly Come Cleaning t-shirts to promote the initiative.

Huw Price, facilities and hotel services manager at Northcroft, dressed up in a tuxedo to compere the final round, where judges gave their scores using glittering paddles.

Behind the glitz and glamour of Strictly Come Cleaning was a strong, strategic plan drawn up to comply with Department of Health and Care Quality Commission guidance, as well as NHS National Healthcare Standards.

The plan was based on three key objectives:

- Setting and achieving consistent, compliant cleanliness standards trustwide,
- ensuring clear responsibilities for all aspects of environmental cleanliness, and
- to raise the plan's profile and the trust's commitment to cleanliness and infection control.

It also emphasised the significant impact of environmental cleanliness on the patient and carer experience and how this can help with recovery and wellbeing.

As a strategic cleaning plan, Strictly Come Cleaning was also designed to be shared with other healthcare organisations.

Strictly Come Cleaning was chosen as the theme to help engage staff, service users and carers in the plan's serious message through a fun and inclusive campaign.

Youthspace

Youthspace, the first national conference on early intervention and youth mental health, was staged by our trust in November 2010.

The two-day event was held at the Botanical Gardens in Edgbaston on November 22-23, brought together more than 300 delegates and experts to discuss developments and research within youth mental health and related services.

Our trust has pioneered the development of early intervention services that are now a staple feature of mental health trusts across the country.

We have extended this approach across a complete spectrum of mental health problems, as more than 75 per cent of enduring mental health issues occur before the age of 25 – mainly during adolescence.

This inaugural Youthspace conference was supported by the Royal College of Psychiatrists, the National Mental Health Develop Unit, National CAMHS Support Services (NCSS) and NHS West Midlands.

But Youthspace is not just a talking shop for clinicians to discuss early interventions, it is led by a Youth Board, who run the Youthspace website - www.youthspace.me - which was also launched in November at the Midland Arts Centre in Edgbaston.

Youthspace.me is a forum where young people can learn, share and talk about some of the things they often don't know how to talk about.

Sam Carter, a member of the Youthspace team, described his experience of working on the website launch as "really beneficial, really interesting".

He added: "I think because this comes from our point of view, it comes across as being genuine, which I think people will appreciate and recognise."

Youthspace is an ambitious redefining of traditional approaches to mental health service provision for young people.

Sarah Butterworth, research fellow working on Youthspace said: "We have listened to what young people want and how they would like to access information. Youthspace was created with young people at the centre of the process.

"We hope that Youthspace will be used not only by young people but also professionals to access relevant and up to date information."

The Youthspace team also work closely in partnership with a variety of agencies across the West Midlands to provide useful information to its visitors.

Circles – service user artwork, Phoenix Centre art group.

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 as a result of their feedback, we have developed a comprehensive three-year communications strategy which was approved by our board in March 2008.

Trust Talk

Our magazine Trust Talk is the main way we communicate with our members and service users.

Copies of this popular bi-monthly publication, which celebrates our achievements, are available at all of our sites. A personal copy is also sent to every member of the trust through the postal service.

Electronic copies are available via email or can be downloaded from our 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 our free member seminars.

Our membership

Our trust is actively recruiting and engaging members, and is committed to creating a dialogue with our communities. Our trust currently has 13,677 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 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.

Map of membership areas

Sutton Four Oaks
Sutton Trinity
Sutton New Hall
Sutton Vesey
Kingstanding
Oscott
Perry Barr
Erdington
Tyburn
Shard End
Sheldon
South Yardley
Washford Heath
Hodge Hill
Stockland Green
Stechford

Handsworth
Wood
Lozells East
Nechells
Aston
Ladywood
Soho
Springfield
Sparkbrook
Bordesley Green

Bartley Green
Longbridge
Northfield
Kings Norton
Brandwood
Billesley
Hall Green
Acocks Green
Moseley
Kings Heath
Edgbaston
Harborne
Quinton
Weoley Castle
Selly Oak
Bournville

Dorridge
Hockley Heath
Blythe
Castle Bromwich
Smith's Wood
Kingshurst
Fordbridge
Bickenhill
Meriden
Elmdon
Lyndon
Olton
Solihull
Shirley East
Shirley South
Shirley West
St Alphege
Knowle

Birmingham East and North PCT
Heart of Birmingham PCT
South Birmingham PCT
Solihull Care Trust PCT

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.

Being a member of BSMHFT is a great way of challenging the stigma and discrimination that people with mental health difficulties can sometimes face.

Members can join the following constituencies depending on where they live:

- Heart of Birmingham
- Birmingham East and North
- South Birmingham
- Solihull
- Rest of England and Wales.

As well as joining the trust depending on where they live, 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.

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.

Members can keep in touch with their governor by sending messages to a dedicated e-mail address contact.governors@bsmhft.nhs.uk, calling the governor liaison office (0121 301 1274), or by writing to the governor c/o: Governor Liaison Office, BSMHFT, 50 Summer Hill Road, Birmingham, B1 3RB.

Engaging with our 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.

The Revolving Door

The Revolving Door film was launched at Aston Villa on May 27, 2010. This event illustrated the commitment of numerous key stakeholders including trust directors, chair and chief executive and Councillor Alan Rudge, of Birmingham City Council, in tackling the many issues surrounding the stigma of mental health. Actress Pasty Palmer shared her experience of mental ill health and reinforced the importance of people supporting one another either in families or in communities. Statements of support for the film were received from Oona King, Channel 4's director of diversity and international poet Benjamin Zephaniah.

To date the team has received more than 400 expressions of interest from external organisations wanting to use The Revolving Door as an educational tool. The trust's community engagement team have worked with many partners including public services, education providers and community groups in order to utilise the film with accompanying training material.

Commitment to community

A series of six mental health awareness seminars took in the Handsworth and Lozells area of the city, as part of Be Birmingham's Handsworth and Lozells Delivery Partnership.

Carol Ann Wilson, the trust's head of spiritual care, spoke at the Regional Action West Midlands (RAWM) Custodians of care: Caring for the community event. These events were developed as a way of different organisations being able to work together to tackle issues being faced by people living in Birmingham and Solihull. The trust's role was to share information and experience of mental health in order to increase understanding by professionals in other services.

Sharon Palmer, chief executive officer of RAWM, said: "Supporting people experiencing severe stress and mental illness is at the heart of our respective roles and it is important that we continue to provide and improve services that are available; this can only be achieved through collaboration and developing shared understanding of the issues"

The trust continues to work with many external organisations in order to benefit the opportunities available for our service users and so that we can help increase an understanding of mental health.

A series of seminars have taken place in Bordesley Green and Small Health in order to raise awareness and understanding of mental health issues. All seminars have been delivered by a variety of trust staff in order to cover a range of key topics in mental health.

World Mental Health Day

The trust partnered with the national campaign to end mental health discrimination Time to Change and local Community Interest Company, Community Vibe, in order to stage a World Mental Health Day event in Cannon Hill Park, Birmingham on October 10, 2010. Professor Peter Marquis, the trust's chairman, opened the event which was supported by more than 40 other local organisations including Birmingham City Council.

Actress Patsy Palmer (centre) with director of community engagement Lakhvir Rellon and Sue Turner, our chief executive, at the launch of The Revolving Door.

The emphasis was on tackling discrimination, promoting physical activities, different mental health services and organisations. A number of trust staff attended and supported the event by providing information for the public and various activities. Sandwell and West Birmingham Hospitals NHS Trust undertook a screening and research audit in order to raise awareness of ill health related to high alcohol consumption. Hundreds of people attended the event during the day, making it a successful and enjoyable occasion.

The Insatiable Moon

The trust was privileged to endorse a feature film based on the true story of a service user who inspired everyone he came into contact with. The Insatiable Moon was written and filmed in New Zealand for a global release. The experiences portrayed in the film, and the discrimination that service users face, is a universal issue. An accompanying documentary was produced using interviews of staff and footage of mental health services in New Zealand, whilst Birmingham and Solihull Mental Health NHS Foundation Trust provided an in-depth depiction of services and experience on this side of the globe.

The film premiered at Birmingham's Cineworld multiplex in October to a full house. The screening was followed by a question and answer session during which the audience was able to ask the film's writer, director, producer and the lead actor about the process and the film's themes.

Unsent Letters tour

This is a collaborative partnership arrangement between Hearth Arts and the trust that uses performing arts and theatre to challenge the stigma and discrimination in mental health.

This partnership work also aims to raise awareness within communities and highlight issues and challenges faced by people with serious and complex mental health issues

The tour targeted two specific areas of Birmingham - Yardley Green, where a new medium secure unit is being built, and Handsworth and Lozells to support the trust's partnership with Birmingham City Council.

Writer Mike Riddell, director Rosemary Riddell and actor Rawiri Paratene at The Insatiable Moon premiere.

Our partnership with the University of Birmingham

This is a partnership between the trust and staff and student wellbeing colleagues at the university. Building on existing links, this partnership aims to:

- Provide information and support to university staff and students with mental health concerns,
- raise awareness about mental health and challenging stigma,
- bring expertise and different perspectives to engagement in mental health, and
- give the trust access to the university's community of 30,000 people (including 6,000 staff) of all ages, ethnicities and backgrounds.

Volunteering

The trust continues to recruit volunteers to specific roles that staff register with the volunteer service. Volunteers make a valuable contribution in a number of areas and we thank them all for their commitment and involvement to the work that we do.

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

Future opportunities will be advertised on the trust website www.bsmhft.nhs.uk.
For more information email volunteering@bsmhft.nhs.uk

Learning disability awareness events

The trust's commitment to improving access to mental health support services for people with learning disabilities is high on the agenda for all staff.

The community engagement team have facilitated several awareness events for trust staff and external interested parties. The trust will continue to work hard at ensuring services are working well for people with mental health and learning disability problems.

non-financial reporting

Sustainability and climate change

Our award-winning trust has continued to demonstrate its commitment to sustainability, reducing its carbon emissions and minimising its impact on the environment and climate change.

Sustainability forms an integral part of the trust's core business. Indeed the garden developed at George Ward was created using mostly sustainable materials and will give our service users a pleasant environment.

Our trust has developed 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 compliant, strategic and sustained approach.

At recent trust AGMs we have displayed information on the many interventions and successes of the approach being taken to sustainability by our trust.

The new Juniper Centre helps to showcase the trust's commitment to sustainability by being our first trust site to have the capacity to develop its own renewable energy via ground source heat pumps and solar-powered air circulation. The renewable energy will not only deliver financial savings to the trust but will also help towards the challenging targets facing all NHS organisations.

Managing energy as a finite resource, minimising and mitigating energy wastage, has also had a positive financial impact on the trust. A combination of the energy consumption savings achieved and lower utility prices in 2010/11 enabled the trust to benefit from a non-recurring cost reduction on 2009/10 costs of £337,000.

Improvements made to provide green space at George Ward

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 into the trust's day-to-day business.

Trust performance analysis

Our performance in 2010/11 measured against the significant achievements in 2008/09 (except waste management) and 2009/10 is as follows.

Carbon management

Table 1: Carbon management (2008-2011)

Year	Electricity, gas and oil (tCO_2)	Transport including taxi, grey fleet vehicles and fleet vehicles (tCO_2)	Waste (tCO_2)	Total (tCO_2)
2007/8:	Baseline year for	energy, waste and transport		13,056
2008/9	11,397	980	175	12,552
2009/10	11,034	938	134	12,106
2010/11	**11,497**	**900***	**91**	**12,488**

** Estimate as data not yet available (May '11)*

Our trust has already made carbon savings related to transport (grey fleet vehicles, fleet vehicles and taxis), energy and waste in the region of five per cent over a period which has seen significant change and new developments to the BSMHFT estate. Furthermore our trust is working nationally to develop a framework for carbon footprinting of mental health services, which will also include carbon footprinting of procurement – an exercise which our trust has already undertaken in 2010/11

Carbon Reduction Commitment (CRC) Energy Efficiency Scheme

Our trust has made a declaration and information disclosure on the CRC as required. It has not traded on the CRC, which means BSMHFT has not procured any carbon credits (allowances) or incurred a financial cost.

BSMHFT 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.

Waste management

Table 2: Waste management 2009/10 and 2010/11

Waste	Non-financial data	Non-financial data		Financial data (£k)	Financial data (£k)
2009/10	**2010/11**			**2009/10**	**2010/11**
Total waste arising	1,258 tonnes	1,229 tonnes	Total expenditure on waste disposal	£184,943	£217,678
Waste sent to landfill	361 tonnes	205 tonnes (+ 58 tonnes to energy from waste)			
Waste recycled	887 tonnes	958 tonnes			
Percentage of waste recycled	70%	77%			
Waste incinerated	10 tonnes	8 tonnes			

Given the significant logistical changes in the trust estate in 2010/11 it is a positive reflection on what and how we utilise what we procure that the total waste tonnages have reduced slightly firm 2009/10 levels, and that a recycling rate of over 70 per cent has been both maintained and improved.

Waste costs have risen by nearly 15 per cent. The cost rises are primarily attributable to increasing landfill tax and disposal costs and higher than average confidential waste costs (an attributable factor being estate rationalisation) plus the costs associated with building closures.

A new service contract has been tendered for 2011 onwards which will see a financial saving in domestic waste disposal.

Finite resources

The table and supporting graphs demonstrate how:

- Gas and electric actual expenditure in 2010/11 decreased from 2009/10 by a total of £337,000.
- Gas consumption in 2010/11 decreased against 2009/10 by two per cent, despite the extreme weather experienced in December 2010.
- Electric consumption in 2010/11 increased against 2009/10 by five per cent. This is predominantly due to the 'double running' costs experienced during 2010/11 while developing new buildings, such as the Juniper Centre, while operating the same estate at the same time. Like for like property electricity consumption was reduced by nearly three per cent.

The trust's Earthman character helps spread energy saving messages.

Figure 1: Utility costs 2008/9 to 2010/11

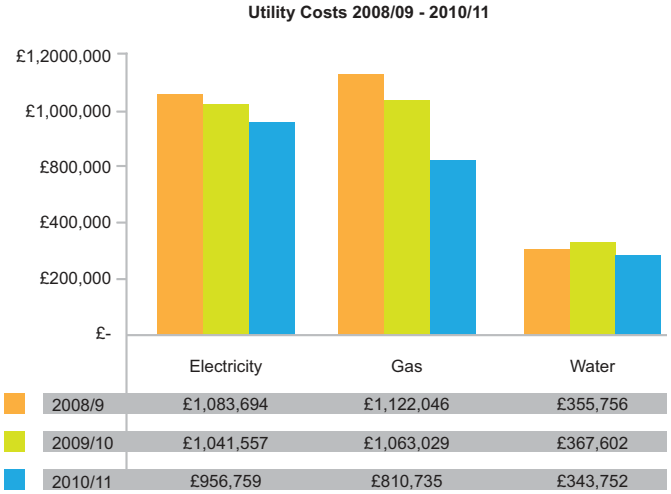


Figure 2: Energy consumption 2008/9 to 2010/11

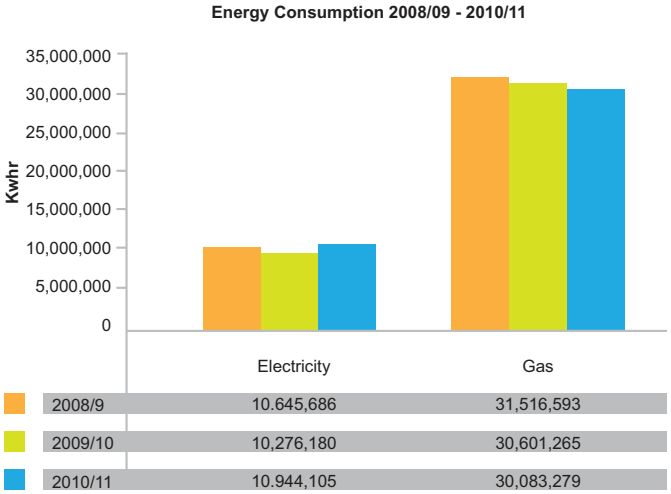
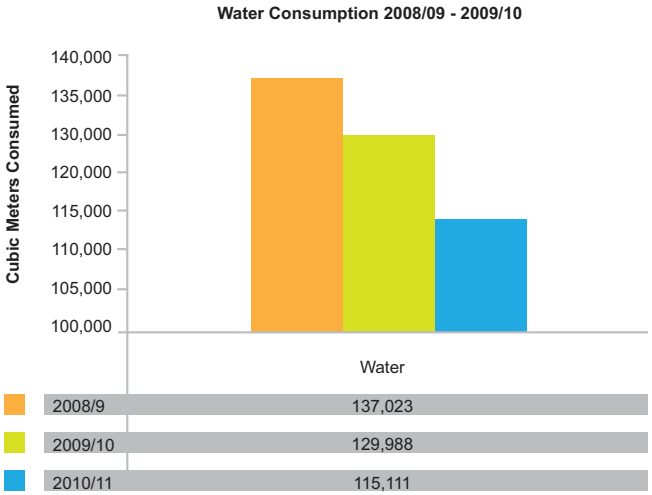


Figure 3: Water consumption 2008/9 to 2010/11



The positive performance on energy, waste and water in 2010/11 being primarily due to:

- Investment in plant, technology and improvements to facilities;
- the continued drive to minimise energy wastage and promote environmental efficiencies; and
- energy and water tariffs/procurement reductions.

Priorities and achievements

Building on achievements made in previous years including 2010/11, for 2011/12 the trust will continue 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. Energy roadshows are being planned for October 2011 to showcase achievements and interventions and to highlight areas where further improvements are necessary.
- Invest where business case exists in environmentally efficient and sustainable products and services. For example working towards an exiting and challenging opportunity of introducing solar panels at one site to enable the trust to not only generate its own electricity but to also be paid for it.
- Work with our partners to drive down waste, increasing recycling further and seek further financial efficiencies.
- Ensure that the Yardley Green 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.

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

Regulatory ratings

As outlined in the tables below, since attaining foundation trust status and for the financial year 2010/11 up to quarter 3, the trust has continued to achieve a governance risk rating of green, in line with its annual plan submission and confirming continuing declaration of compliance with the trust's Terms of Authorisation in line with Monitor's Compliance Framework requirements.

For 2010/11, as at Quarter 4, the trust has submitted to Monitor a governance rating of amber-red which was generated as a result of the outcomes of a Care Quality Commission responsive review undertaken in February 2011. The actions being taken by the trust to address the issues raised by the Care Quality Commission are detailed on page 27 of the annual report.

Table 3: Financial and governance risk ratings for 2009/10 and 2010/11

	Annual Plan Plan 2009/10	Quarter 1 2009/10	Quarter 2 2009/10	Quarter 3 2009/10	Quarter 4 2009/10
Financial risk rating	4	4	4	4	3
Governance risk rating	Green	Green	Green	Green	Green
	Annual Plan 2010/11	**Quarter 1 2010/11**	**Quarter 2 2010/11**	**Quarter 3 2010/11**	**Quarter 4 2010/11**
Financial risk rating	3	4	4	4	4
Governance risk rating	Green	Green	Green	Amber-green	Amber-red

Table 4: Monitor 2010/11 Compliance Framework: Delivery of national indicators for mental health foundation trusts

Monitor Indicators 2010/11	Monitor threshold	Score for non compliance	Quarter 1	Quarter 2	Quarter 3	YTD at Q3
1. 100% of Care programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital	95%	0.5	96.6%	96.4%	98.2%	97.3%
2. 100% of Care programme Approach (CPA) patients receiving formal review in past 12 months	95%	0.5	95.3%	95.07%	95.6%	95.6%
3. Minimising delayed transfers of care (Excluding social care delays)	<7.5%	1.0	3.8%	3.13%	3.2%	3.2%
4. Admissions to inpatient services having access to crisis resolution home treatment teams	90%	1.0	99.3%	98.5%	99.3%	99.2%
5. Meeting commitment to serve new psychosis cases by early intervention teams based on trajectories agreed with commissioners	95%	0.5	100%	100%	100%	100%
6. MHMDS Data completeness - identifiers: NHS number, date of birth, postcode, gender, marital status, GP code and commissioner code	99%	0.5	99.1%	99.3%	99.3%	99.3%
7. Access to healthcare for people with learning disabilities – compliance against six criteria	n/a	0.5	Compliant	Compliant	Compliant	Compliant
8. MHMDS Data completeness - outcomes: • % discharged patients with employment status recorded • % discharged patients with accommodation status recorded • % having HONOS assessment in past 12 months	50% (introduce from quarter 3)	0.5	N/A	N/A	78.5%	78.5%

Developing services and improving patient care

The performance of our trust is assessed, like other organisations, through a number of national and local methods. Nationally our performance is monitored by the Care Quality Commission (CQC), through annual and periodic reviews, service reviews and surveys.

In addition, the local performance of our services is monitored and reviewed by our commissioners, which includes primary care trusts, local authorities and drug action teams.

Established performance management processes are in place to ensure continued progress as well as ensuring that areas for improvement are identified, taking targeted action where necessary.

As we are a foundation trust, our performance is also reviewed by Monitor who do this through a compliance framework and the publication of quarterly governance and mandatory service risk ratings.

We continue to work in partnership with third party organisations within our geographical boundary, including overview and scrutiny committees, local involvement networks and community groups to ensure they are kept well informed of our performance.

This section provides an overview of our performance against key targets. For the purpose of this report, this section relates to the 12 month period of 2010/11.

Quality of services

The trust was subject to a Care Quality Commission (CQC) responsive review in February 2011. As a result of the review the CQC identified four areas of moderate concerns and one area of major concern (safeguarding people).

A range of actions have been identified to address these concerns which have been confirmed with the CQC. Overall these include:

- To review and strengthen the trust's safeguarding procedures and ensure that staff are fully aware of their reporting requirements.
- To further improve understanding and awareness of Deprivation of Liberty Safeguards (DOLS) procedures.
- To review provision of breakfast in relation to specific needs of ethnic communities.
- To ensure consistent approaches are in place for communications between teams.
- To improve procedures to ensure all potentially notifiable incidents are correctly coded.

In relation to some of the CQC's concerns, a number of actions had already been addressed or were in the process of being addressed at the time of the visit. These related to:

- Introduction of a revised clinical risk assessment tool.
- Improvements to monitoring arrangements for staff training
- Arrangements for communication between acute adult service teams.
- Monitoring arrangements for statutory and mandatory training.

Since attaining foundation trust status and for this financial year, 2010/11, the trust has confirmed continuing compliance with the relevant national mental health indicators and performance thresholds as outlined in Appendix B of Monitor's Compliance Framework.

These indicators were:

- 100 per cent of Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital.
- 100 per cent of CPA patients receiving formal review in past 12 months.
- Minimising delayed transfers of care (excluding social care delays).
- Admissions to inpatient services having access to crisis resolution home treatment teams.
- Meeting commitment to serve new psychosis cases by early intervention teams based on trajectories agreed with commissioners.

MHMDS Data completeness - identifiers: NHS number, date of birth, postcode, gender, marital status, GP code and commissioner code.

Access to healthcare for people with learning disabilities – compliance against six criteria.

MHMDS Data completeness - outcomes:

- Percentage of discharged patients with employment status recorded.
- Percentage of discharged patients with accommodation status recorded.
- Percentage of having Health of the Nation Outcome Scale (HONOS) assessment in past 12 months.

As a result of the concerns raised by the CQC, the trust submitted to Monitor an amber/red governance rating for Quarter 4. The trust's plan aims to address these concerns by the end of Quarter 1 in 2011/12, to demonstrate an improved governance rating for the remainder of that year.

Waiting times

Our trust has consistently met the national outpatient waiting time standards of no more than 11 weeks. On average our service users wait three weeks for an outpatient appointment, with the vast majority (93 per cent) seen within six weeks.

Delayed transfers of care

We continue to work hard to reduce the number 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 support and ensure appropriate, safe and timely discharge.

The average number of delayed transfers of care each week has fallen from 23.6 in 2009/10 to 23 in 2010/11. 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.

Seven day follow-up

Our trust strives to meet the national target of ensuring that all patients are appropriately followed up within seven days of being discharged from hospital. Evidence has shown that this is the time some patients feel most vulnerable and are more at risk of committing suicide.

We have continued to exceed the target set by Monitor of 95 per cent. In 2010/11, 97 per cent of patients were followed up within seven days of discharge.

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.

We have also developed annual health and wellbeing roadshows to raise awareness regarding health issues among staff. It is encouraging that average sickness levels have fallen every year since 2007/8 but that there remains room to reduce these even further.

Figure 4: Delayed discharges – percentage of occupied bed days delayed

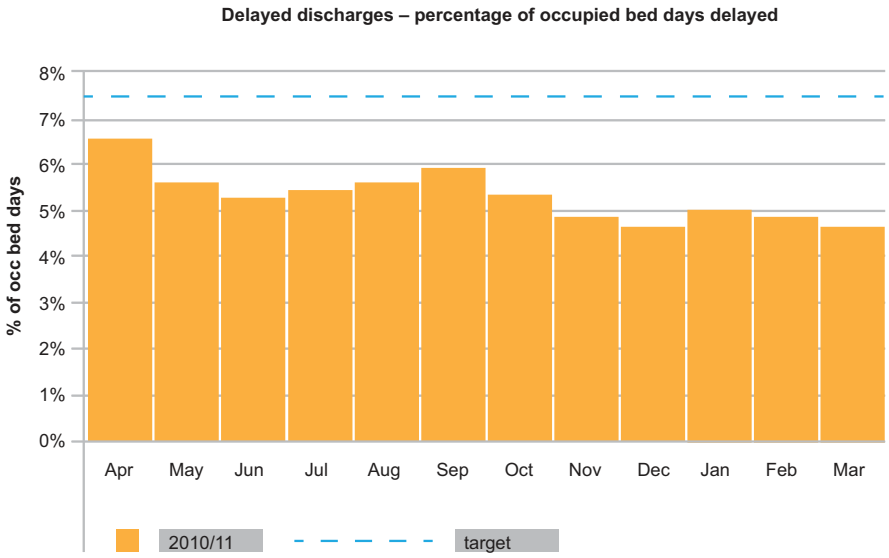


Figure 5: Seven day follow-up percentage of discharges

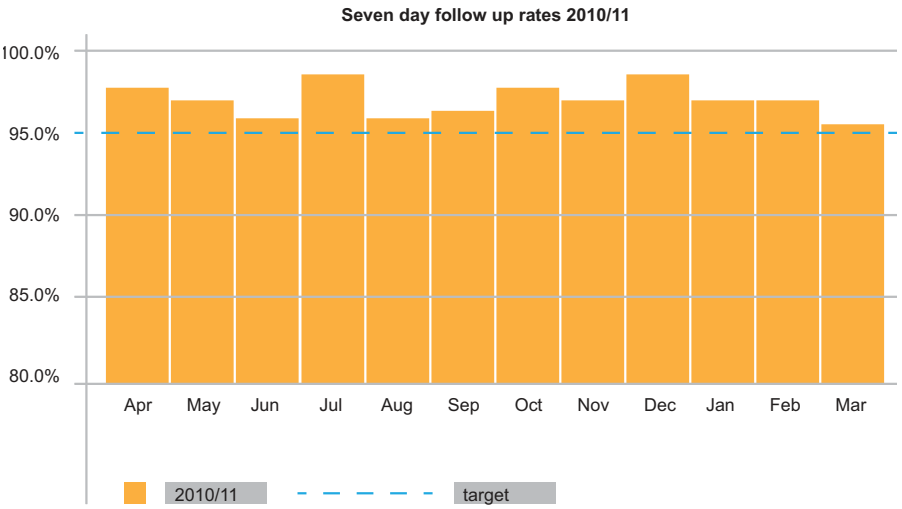
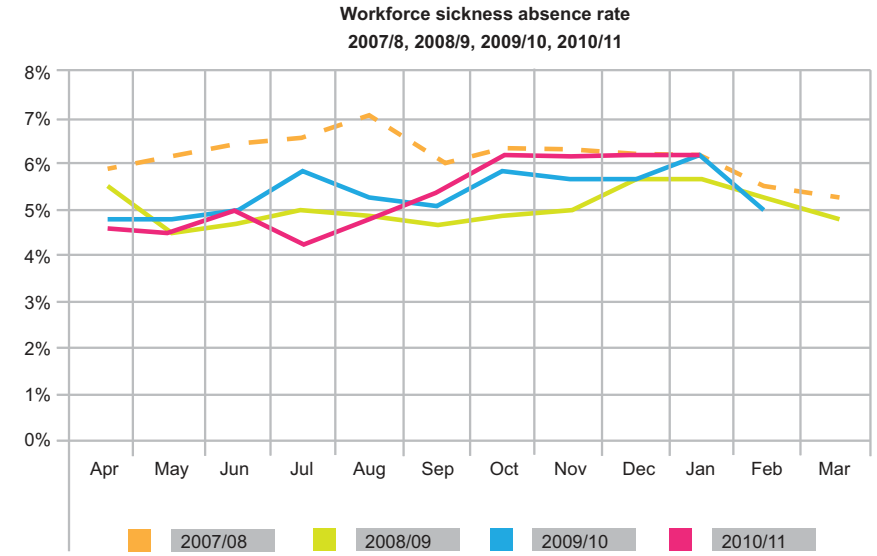


Table 5: Sickness absence by percentage April 2010 to March 2011

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
4.7%	4.6%	4.9%	4.5%	4.8%	5.4%	6.1%	6.1%	6.1%	6.1%	4.8%	5.2%

Figure 6: Workforce sickness absence rates 2007-2011



quality report

Part 1: Statement on quality from the chief executive

I am proud to present our quality account for the trust and the opportunity this gives me to highlight the quality of services we provide.

Over the past year the trust has made significant steps to further improve our service.

The development of our new facility for older people, the Juniper Centre at Moseley Hall Hospital, is a significant improvement to our service. However more important is the work that has been undertaken to match this 21st century centre with a whole transformation of our services to significantly improve the quality of care we provide.

Significant effort has been made to engage staff, service users and carers in this process and deliver consistent and high quality division-wide services through inpatient, therapy suite, outpatients and education centre alongside local services through its function as a community team base.

The results from the national patient survey highlighted four areas where the trust achieves scores in the top 20 per cent of comparative trusts, and 26 areas out of a total of 40, where our responses are consistent with most other trusts.

This quality report shows how the trust has improved quality standards against four priority areas identified in 2009/10. Although we did not achieve targets set in two areas last year, there are still significant improvements. We have plans that will ensure those targets are met this year, although we also recognise the need to balance our ambitions against the various every day pressures.

New initiatives that have had a major impact on improving quality of care over the past 12 months include:

- E-rostering service, to enhance the coordination of roster arrangements for our inpatient teams;
- improving arrangements for joint working and transferring service users across teams;
- development of a place of safety service for management of urgent admissions.
- Developing provision of psychological therapy services

Over the next year we are further investing in new systems to further increase the quality of our care. These include:

- The implementation of the new electronic patient record system which will support the highest standards of care.
- Introduction of a new risk management system to provide a facility for staff to report incidents electronically and also to be able to interrogate trend data in a timely way.
- Further development of our real time feedback systems for service users to tell us how they feel about the quality of their service.
- The development of a new state of the art medium secure facility.

The CQC undertook a responsive review in February 2011. As a result of the review, the CQC made

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

Priorities for improvement identified in 2010/11

Last year the trust identified four priorities for improvement the outcomes of these are set out below.

SAFETY OBJECTIVE: *To ensure all staff working in inpatient units have received training in relation to the management and prevention of violence.*

Aims

The aim of the objective was to refocus training relating to management and prevention of violence to more staff across the trust ensuring 95 per cent of all inpatient staff were up to date with trust training requirements by end of 2010/11.

Outcome

The trust reviewed and revised its training programme to support staff in managing violence and reduced the length of the course to enable attendance to be improved.

A new database to manage and monitor staff training requirements has been introduced and therefore comparative data is not available.

By the end of the year, the trust had improved overall compliance to 58.9 per cent. However a further 18.1 per cent were still undertaking training.

Further plans are in place to achieve

recommendations in relation to five of the standard reviews. These were moderate concerns relating to four standards and a major concern relating to safeguarding people who use services from abuse. Actions have been agreed to address these concerns by the end of June 2011.

The quality of care experienced by our service users particularly reflects the professionalism and commitment from all of our staff and this report is a testimony to the work of everyone within our trust. Some of these achievements are reflected by national awards which have been received by staff teams this year. These include:

- HSJ Award for innovation in mental health for the Rapid Assessment Interface and Discharge (RAID) service our trust provides at City Hospital via its A&E department.
- HSJ/Nursing Times Patient Safety Award to Staff at Ardenleigh (forensic unit for child and adolescent mental health) for its innovative approach to reducing violence.
- Cost Sector Catering Award for healthcare to our head of facilities.
- The Institute of Ageing and Health Excellent Care Award to our community personality disorder service for the Stop and Think group programme.

This report has been produced following engagement and feedback from service user and carer representatives, local teams and staff across the organisation. In order to identify our priorities for the year we instigated a consultation exercise to ask staff, service users and representatives for their views on the simple question - how to measure quality.

This has included the engagement of:

- Trust board and senior directors,
- the Assembly of Governors,
- service user and carer representatives,
- Local Involvement Networks (LINks),
- Our commissioners and particularly our lead commissioner – BEN PCT, and
- trust and local programme clinical governance committees.

It is not possible to include everyone's contribution within this report but our consultation has helped to identify priorities for improvement.

Overall the quality of care our service users receive reflects the commitment and professionalism of all our staff and this report is a testimony to their work within our trust.

To the best of my knowledge the information contained in this report, which has been revised by the trust board through the year, is accurate.

Sue Turner
Chief executive

June 2, 2011

full compliance by February 2011.

See Part 3 for a more detailed breakdown.

CLINICAL EFFECTIVENESS
OBJECTIVE: *To reduce the levels of antipsychotics prescribed to service users with dementia against national benchmark*

Aims
To achieve 10 per cent below average benchmark levels of usage of antipsychotic drugs for service users who are suffering dementia.

Outcome
New clinical guidelines were developed and agreed within the trust for prescribing of antipsychotics to service users with dementia.

The guidelines were disseminated and an initial audit was undertaken of practice. This highlighted significant variation of prescribing levels across the organisation.

The recent Prescribing Observatory Mental Health (POMH-UK) audit included inpatients and for the first time community patients. The final report is expected in July 2011 and this will enable our trust to be benchmarked for the first time with other mental health trusts.

The outcome of further audits against four wards identified is set out below. The wards were selected to provide a cross section of clinical teams.

Table 6: Prescribing of antipsychotics in dementia across four trust units

Ward	Sep-10	Jan-11	Mar-11
Hollyhill	37%	40%	38%
Nightingale	50%	43%	21%
Rosemary	63%	42%	42%
Sage	100%	54%	59%
Total	**60%**	**46%**	**40%**

CLINICAL EFFECTIVENESS OBJECTIVE: *To develop the use of outcome measures in all clinical services.*

Aims

To develop a suite of outcome measures to ensure that service outcomes can be clearly demonstrated.

Outcome

A major focus across the trust over the past year has been the importance of the use of outcome measures. A range of tools are now in use as follows:

Table 7: Outcome measures used in clinical services

Programme	Tools in use
Acute services: Adults of Working Age	Inpatients: Health of the Nation Outcome Scale (HoNoS) and Ward Atmosphere Scale piloted within assertive outreach teams.
Community: Adults of Working Age	HoNoS The trust has participated in a collaborative project with the Royal College of Psychiatrists to develop outcome measures for community mental health teams, and as a result has agreed the adoption of Carer and User Expectations of service (CUEs) for all teams.
Non acute: Adults of Working Age	Hold Assessment Suites
Older People Services	The programme has an outcome measure strategy and has introduced the first tier of this - indication of symptom severity and life satisfaction.
Addictions	Treatment Outcome Profiles (TOPs) Client evaluation of self at intake (CESI)
Secure and complex care	HoNoS Secure Recovery star
Youth	Global Assessment of Functioning (GAF) Positive and Negative Syndrome Scale (PANSS) Calgary Depression Scale

These tools reflect all the core areas of services offered across the trust.

Further work is identified to develop the use and learning from outcome measure tools. In the coming year, it is proposed to monitor the number of service users with a health outcome measure recorded at initial contact and subsequent review in line with NICE standards.

Last year the trust achieved a 90 per cent standard in relation to recording HoNoS scores for all new referrals. This standard has continued to be med throughout the year.

USER EXPERIENCE OBJECTIVE: *To increase patient and carer involvement in the planning of their care and treatment.*

Aims

To demonstrate an improvement in experience of patient and carer involvement in the planning of their care and treatment. Achieving a five per cent improvement in national patient survey score in relation to Your Care Plan.

Outcome

The trust has taken a number of steps to improve patient and carer involvement in the planning of their care and treatment. A baseline audit has been undertaken of the trust's integrated care record and will be reported quarterly. A comparison of data with last year is set out below.

In addition the trust has introduced an audit report on the trust care record to identify the level of carer assessments this will be reported regularly to further monitor and improve support provided.

Table 8: Percentage service user views recorded in record documents

	2009/10 (to Feb 2011)	2010/11
Adult acute in patients	60%	70%
Non acute inpatients	68%	83%
Community mental health teams	68%	81%

Table 9: Percentage of service users who felt included in their care plan

Patient Survey question *(CQC Community Mental Heatlh Survey)*	Patient Survey 2008/9*	Patient Survey 2010/11	Bench mark
Percentage of service users who say they have been given or offered a written/printed copy of their care plan in the last year.	49%	63 %	67% average
Percentage of service users who think their views were taken into account when deciding what was in their care plan.	50%	65%	70% average

** Patient Survey for 2009/10 related to inpatient care only*

Single mother and student Simone Daniel enjoys her role as live-in carer for her grandmother Daisy.

Priorities for improvement for 2011/12

The trust launched a consultation process to identify key clinical quality indicators for this quality account in January 2011. All staff were invited to contribute and were able to post suggestions on the trust intranet and through an e-survey form.

Similar requests were issued to commissioners, LINKs and other user and carer groups.

A special consultation event was also arranged with assembly of governor members.

As a result of all comments received and other indicators identified relating to NICE and national indicators, a short list was developed to assess the reliability, ease of use and impact for each indicator.

This was then presented to an informal meeting of trust board members who prioritised the following priorities for the year ahead:

SAFETY OBJECTIVE

Reduce the number and severity of recurring assaults caused by individual patients.

Rationale	Any assault which occurs on an inpatient ward has a potential to cause harm to staff or other service users. Further such incidents impact negatively on the therapeutic environment. Interrogation of incident data has highlighted levels of recurring incidents which relate to the same service user and therefore there is scope to develop stronger mechanisms to manage this. Work undertaken within our adolescent services to reduce the level of assaults (which won a HSJ/Nursing Times Patient Safety Award) has highlighted issues for learning which could be applied to other inpatient teams across the trust.
Aims	The focus will be 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.
Current status	Significant work has been undertaken in the adolescent service to reduce the level of assaults/violent incidents and it is proposed that lessons from this are adopted in other areas.
Plans	A good practice guide will be developed reflecting experience of Adolescent service and wider best practice. Reporting arrangements will be developed to trigger reoccurring incidents in wards.
Monitoring and reporting	Monitoring will be undertaken through the number of incidents and also the degree of harm/risk identified in relation to individual incidents. This will be reported through routine incident data reports. Measures: Number of assault incidents, level of harm of assault incidents (risk score), reported by incident reports.
Leads	Director of patient experience and service improvement.

CLINICAL EFFECTIVENESS OBJECTIVE

Improve reporting of physical health assessments within user records

Rationale	The trust is committed to supporting the physical health needs of its service users and has had in place a strategy over the past two years to improve physical healthcare. This has ensured the provision of appropriate equipment, guidance and training to staff. The consistency of approaches within community services has been identified to be variable often due to external factors.
Aims	Arrangements for ensuring service users have received appropriate physical health assessments will be strengthened across all services.
Current status	The level of physical health assessments has improved over the past year and is reflected in audits of individual care records. However consistency of standards is variable across services, particularly in community services where primary care play a key role in communicating assessments.
Plans	Existing guidance will be strengthened and reinforced. Monitoring of compliance will be through the trust's existing electronic care record audit process. This will highlight to teams areas where assessment are not routinely undertaken. Work will also be identified to improve arrangements with primary care for sharing of physical health monitoring information.
Monitoring and reporting	Completion of relevant fields of the care record will be monitored as part of routine electronic audit. Measure: Percentage of care record completed for fields.
Leads	Director of patient experience and service improvement / Head of physical therapies / Health and wellbeing.

USER EXPERIENCE OBJECTIVE:

Improve patient satisfaction in relation to care plan and overall levels of care

Rationale	The trust is committed to developing ways to improve feedback from service users and use this to improve the quality of our services provided. A pilot use of real time feedback mechanisms is in place and this will lead to a more comprehensive use of these units across the trust.
Aims	To introduce the use of electronic real time feedback mechanisms to drive demonstrable improvements to perceived quality of service by service users.
Current status	The trust is rolling out a network of real time feedback monitoring systems across services.
Plans	A baseline of service user views will be confirmed with the introduction of the new units. Results will be feedback to individual services to identify opportunities for improvement.
Monitoring and reporting	The objective centres on the use of real time monitoring systems to provide direct feedback of service users views in relation to these areas: • Care plan feedback, • overall expressions of care provided, and • awareness of care plan/involvement. Measure: Average level of feedback.
Leads	Director of patient experience and service improvement / Head of patient and public involvement.

Each of these priorities will be monitored as part of the routine clinical governance reporting processes on a local team to board approach.

Cumulative data on each priority will be reported to the clinical governance committee and further reported to trust board.

Statements of assurance from the board

Review of services

During 2010/11 Birmingham and Solihull Mental Health Foundation Trust provided and/ or sub-contracted 17 NHS services.

BSMHFT has reviewed all the data available to them on the quality of care in 17 of these NHS services.

The income generated by the NHS services reviewed in 2010/11 represents 100 per cent of the total income generated from the provision of NHS services by BSMHFT for 2010/11.

Participation in clinical audits

During April 2010 to March 2011, four national clinical audits and two national confidential enquiries covered NHS services that BSMHFT provides.

During that period BSMHFT participated in 100 per cent of national clinical audits and national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that BSMHFT was eligible to participate in during April 2010 to March 2011 are as follows:

- National Clinical Audit of Falls
- National Clinical Audit of Psychological Therapies for Depression and Anxiety
- National Clinical Audit of Schizophrenia (yet to commence)
- Prescribing in Mental Health Services.
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

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- National Clinical Audit of Psychological Therapies for Depression and Anxiety
- National Clinical audit of Schizophrenia (yet to commence)
- Prescribing in Mental Health Services
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

The national clinical audits and national confidential enquiries that BSMHFT participated in, and for which data collection was completed during April 2010 to March 2011, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

- National Clinical Audit of Falls – Organisational data only
- National Clinical Audit of Psychological Therapies for Depression and Anxiety – three services, all patients (100%) applicable for the audit (912)
- National Clinical Audit of Schizophrenia (audit not started)
- Prescribing in Mental Health Services – Trust taking part in all components of the audits (100%).
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (100%).

The report of one national clinical audit was reviewed by the provider in April 2010 to March 2011. This relates to three issues undertaken within the Prescribing Observatory audit and Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Additional training provided to doctors for medicines reconciliation.
- Programme of focused pharmacy support provided to assertive outreach teams in relation to metabolic side effects of antipsychotic drugs.
- Information booklets issued to all community teams on prescribing lithium.

The trust achieved a full compliance score in relation to prescribing of antipsychotic medication in children and adolescents, therefore no actions were identified.

The reports of 63 local clinical audits were reviewed by Birmingham and Solihull Mental Health NHS Foundation Trust in April 2010 to March 2011 and Birmingham and Solihull Mental Health NHS Foundation Trust intends to or has taken the following actions to improve the quality of healthcare provided:

- Reduction and improvements in consistency of practice relating to the prescribing of anti-psychotics in older people with dementia.
- A dedicated allergies section incorporated into physical health assessment form.
- MHA checklist monitoring tool has been updated to include documentation of capacity assessment; the tool is completed on weekly basis for sectioned patients.
- Improvements in process for sending letters to GPs when patients do not attend appointments.
- Improvements to documentation for community treatment orders in early intervention services.
- Improvements in transfers to primary care for prescribing for early intervention patients.
- A range of improvements made to maintain compliance with infection control requirements.

Research

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Birmingham and Solihull Mental Health Foundation Trust in 2010/11 that were recruited during that period to participate in National Institute for Health Research studies approved by a research ethics committee was 1,126.

Goals agreed with commissioners

Use of the CQUIN payment framework

A proportion of trust income in 2010/11 was conditional on 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 (CQUIN) payment framework.

Further details of the agreed goals for 2010/11 and for the following 12 month period are available on request from Georgina Dean, director of finance. http://www.bsmhft.nhs.uk/publications

Overall the trust received 96 per cent of goals agreed with commissioners under the CQUIN element of contracts (£2,664,000 out of a potential £2,764,000).

Registration with the CQC

Birmingham and Solihull Mental Health Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'registered, no conditions'.

The Care Quality Commission has not taken enforcement actions against Birmingham and Solihull Mental Health Foundation Trust during 2010/11.

Birmingham and Solihull Mental Health Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during February 2011.

Responsive review: This was in response to a number of unexpected deaths which occurred within the year.

The CQC reviewed compliance with five regulation outcomes:

Outcome 4 -Care and welfare of people who use services: People experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

Outcome 7 - Safeguarding people who use services from abuse: People are safeguarded from abuse, or the risk of abuse, and their human rights are respected and upheld.

Outcome 13 - Staffing: People are kept safe, and their health and welfare needs are met, because there are sufficient numbers of the right staff.

Outcome 14 - Supporting workers: People are kept safe, and their health and welfare needs are met, because staff are competent to carry out their work and are properly trained, supervised and appraised.

Outcome 18- Notification of death of a person who users services.

The CQC made moderate concerns in relation to four outcomes (4, 13, 14, and 18) and one major concern in relation to outcome 7 (safeguarding people).

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

- To review and strengthen the trust safeguarding procedures and ensure that staff are fully aware of their reporting requirements.
- To further improve understanding and awareness of Deprivation of Liberty Safeguards (DOLS) procedures.
- To review provision of breakfast in relation to specific needs of ethnic communities.
- To ensure consistent approaches are in place for communications between teams.
- To improve procedures to ensure all potentially notifiable incidents are correctly coded.

Birmingham and Solihull Mental Health Foundation Trust has made the following progress by 31 March 2011 in taking such actions as follows:

- In relation to some concerns raised by the CQC a number of actions had already been addressed or were in the process of being addressed at the time of the visit. These related to:
- Introduction of a revised clinical risk assessment tool.
- Improvements to monitoring arrangements for staff training
- Arrangements for communication between acute adult service teams
- Monitoring arrangements for statutory and mandatory training.

NHS Number and General Medical Practice Code Validity

Birmingham and Solihull Mental Health NHS Foundation Trust submitted records during April 2010 to March 2011 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:
  98.7 per cent for admitted patient care; and
  99.5 per cent for out patient care;
- which included the patient's valid General Medical Practice Code was:
  100 per cent for admitted patient care; and
  100 per cent for out patient care.

Information Governance Toolkit attainment levels

Birmingham and Solihull Mental Health NHS Foundation Trust's Connecting for Health Information Governance Report overall score for 2010/11 financial year was 71 per cent and was graded not satisfactory.

An action plan is in place for 2011/12 to further improve performance across all areas.

Statement on relevance of data quality and action taken to improve data quality

Birmingham and Solihull Mental Health NHS Foundation Trust will be taking the following actions to improve data quality during 2011/12:

- Implementation of a new clinical information system with many features supporting improved data quality.
- Ongoing 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.
- Introduction of a full programme of clinical coding training for inpatient medical staff.
- A wide range of data quality audit activities, including audit of clinical coding and other key reporting data items, with special audits to be commissioned should more deep-seated data quality problems be identified.
- Introduction of improved procedures to maintain the accuracy and currency of staff employment details to support operational management and governance activities.

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 the 2010/11 financial year.

Part 3: Other information

An overview of the quality of care offered by Birmingham and Solihull Mental Health NHS Foundation Trust based on performance in 2010/11 against indicators selected by the board in consultation with stakeholders, with an explanation of the underlying reason(s) for selection.

A number of indicators reported in last years report have remained constant for the whole year. These are:

- MRSA bacteraemia (nil)
- Never events (nil)
- Completion of HoNoS scores (Over 90 per cent)
- CBT activity

The annual level of suicides indicator reported last year highlighted that there were arrange of external issues which impacted on the relevance of this as a quality indicator and no readily available benchmark.

Coding in relation to absent without leave (AWOL)/absconsion incidents has been revised during the year, and therefore current data does not provide a consistent picture for review.

PATIENT SAFETY

QUALITY INDICATOR DESCRIPTION	DATA	OVERVIEW OF PERFORMANCE
INCIDENT REPORTING TIMELINESS Trust policy states that all incidents should be received at the risk management office no later than 14 days following the incident. This provides time to ensure local managers have responded fully to the incident. This indicator was introduced in 2009/10. ***Why was this indicator important to us?*** This indicator was identified to place an emphasis on prompt reporting of all incidents. This provides the opportunity for prompt review of incidents at local and corporate level.	**Jan** 92.3%, **Feb** 93.3%, **Mar** 89.3%, **Apr** 88.8%, **May** 90.1%, **Jun** 91% **Jul** 91%, **Aug** 86%, **Sep** 90%, **Oct** 90%, **Nov** 92%, **Dec** 85% *Note: Due to the process of entering data onto the database data is presented with a three month time lag.* *Data source: Incident management database*	The use of this measure has effectively demonstrated improvements in performance across all services when introduced last year, and has remained consistent during the year. ***How we compare with others:*** The trust has significantly improved reporting to the national learning system (Source: National Patient Safety Agency) and is currently the sixth highest mental health trust (two years ago it was the fourth lowest).
VIOLENT ASSAULTS ON STAFF ***Why was this indicator important to us?*** Assaults are a significant issue in relation to safety of staff, but also reflect the quality of the therapeutic environment.	Number of assaults reported (incident forms) **Apr** 44, **May** 63, **Jun** 63, **Jul** 59, **Aug** 53, **Sep** 58 **Oct** 55, **Nov** 65, **Dec** 43, **Jan** 47, **Feb** 46, **Mar** 33 Annual total = 629 *The annual total number of incidents reported in 2009/10 was 382.* *Data source: Incident management database*	There was an increase in violence assaults reported mid year. This led to a programmed review of data at an operational level and learning from some of the incidents which have been reported. This is proposed as an improvement priority for 2010/11. ***How we compare with others:*** NPSA data issued by the national reporting and learning system highlights that while the trust reports overall a higher level of incidents relating to disruptive behaviour, (25.9% compared to national average of 22.6%) the trust reports significantly higher number of incidents overall with no harm (83.5% compared to national average of 62.6%).

PREVENTING VIOLENCE AND AGGRESSION TRAINING

To ensure all staff working in inpatient units have received training in relation to the management and prevention of violence.

Why was this indicator important to us?
There is significant evidence to show that appropriate training in techniques to reduce the impact of aggression reduces injury and improves care to service users.

The trust had identified a number of incidents where staff had not received appropriate training at the time of the incident, this was in part due to the length of the training. A priority was therefore set to make the training shorter and more accessible to enable all in patient staff to receive full training and regular updates

Jul 10	Aug 10	Sep 10	Oct 10	Nov 10
42.38%	44.62%	36.37%	37.74%	35.71%
Dec 10	**Jan 11**	**Feb 11**	**Mar 11**	
58.07%	59.12%	58.86%	Verified data unavailable	

The data above reflects compliance with statutory and mandatory training requirements in relation to prevention of violence and aggression.

A new database to manage and monitor staff training requirements has been introduced and therefore comparative data is not available with the previous year.

Data source: Training Database

The trust has demonstrated an improvement in compliance. Additional training is identified to achieve the target and training and local operational plans are in place to achieve this by February 2012.

How we compare with others:
The trust is aiming to ensure it meets NICE guidance best practice. However national figures are not available.

CLINICAL EFFECTIVENESS

QUALITY INDICATOR DESCRIPTION	DATA	OVERVIEW OF PERFORMANCE

ICR Compliance
The level of completeness of core fields within the patient care record.
Target 80% compliance

This indicator was in use for 2009/10 although at the time reflected a smaller proportion of trust services.

Why was this indicator important to us?
The trust's integrated care record has been developed to reflect best practice in relation to patient care record keeping. Compliance with the required fields therefore supports good clinical practice in relation to clinical care, transfers, risks assessment and service users' views.

	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
Trust total	56%	56.7%	58%	57.7%	58.7%	60%	62.3%

This data reflects the level of compliance with the 80% compliance target.

Data source: Electronic audit of care record

Note: The electronic audit was introduced in August 2010. Preceding data is not directly comparable.

There has been a slow but steady increase in performance of compliance with all ICR fields.

Overall performance is variable with standards in inpatients significantly higher.

SEVEN DAY FOLLOW-UP FROM DISCHARGE

Why was this indicator important to us?
This is a national indicator which reflects good practice in relation to suicide prevention.

End of year figure 96.9%

Apr	May	Jun	Jul	Aug	Sep
98.0%	97.5%	85.9%	98.2%	95.7%	95.9%
Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
97.8%	97.3%	98.7%	97.0%	97.1%	95.3%

Last year the trust achieved an end of year figure of 97.8%

Data source:EPEX

Overall the trust has achieved an average figure above its target of 96.8 per cent

How we compare with others:
The national target for this indicator is 95%.

USE OF ANTIPSYCHOTIC DRUGS IN DEMENTIA

Why was this indicator important to us?
This reflects a target set last year to improve prescribing practice and reflect best practice nationally.

Ward	Sep 10	Jan 11	Mar 11
Hollyhill	37%	40%	38%
Nightingale	50%	43%	21%
Rosemary	63%	42%	42%
Sage	100%	54%	59%
Total	**60%**	**46%**	**40%**

Results of audit % level of antipsychotic drugs for patients with dementia.

Data source: Clinical audit results.

The trust has achieved a positive reduction in the level of antipsychotics prescribed as a result of the development of clinical guidelines and review through clinical audit.

QUALITY INDICATOR DESCRIPTION	DATA	OVERVIEW OF PERFORMANCE

MYSTERY SHOPPING

Compliance with a range of core standards identified by mystery shopping assessment.

Why was this indicator important to us?
The Mystery Shopper programme reflects a core review of standards which have been identified by service users and which are monitored by service users.

	2009%	Q1 10/11%	Q2 10/11%
Welcome board/names	65.2%	52.9%	54.5%
Info leaflets 1-10	77.3%	94.1%	100%
Info In different languages	23.5%	17.6%	18.2%
PALS leaflet or poster Visible	86.4%	76.5%	90.9%
Water available	72.7%	70.6%	100%
Seats and area to talk	100%	100%	54.5%
Staff wearing name badges	63.6%	76.5%	54.5%
Induction Loop available	23.5%	70.6%	9.1%
Toilet available and stocked	91.3%	94.1%	100%
Reception area confidentiality	N/A	88.2%	100%
Disabled parking	64.7%	94.1%	90.9%

The data collated here reflects mystery shopping reviews which have been undertaken randomly across sites in the trust. Therefore it is more difficult to make direct comparison over the period.

Where shortfalls are identified actions are confirmed by local managers and these are reported when complete to the trust's clinical governance committee.

Follow up visits are now planned to address areas which are identified to be poor.

The programme of visits was suspended for a short period of time to enable recruitment and training of new shoppers.

TIMELINESS OF COMPLAINTS

Percentage of complaint responses issued within the timescales agreed with the complainant.

Why was this indicator important to us?
This indicator highlights the extent to which we are able to respond fully to complainants within the timescales originally agreed. While this period is subject to individual review with complainants, the intention is to set timescales which can most realistically balance the need to respond swiftly against the need to ensure proper investigations are undertaken.

Apr	May	Jun	Jul	Aug	Sep
91.3	91.3	100	94.6	88.9	88.9
Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
88.9	96	83.3	77.4	89.5	80.7

% of complaint responses issued within the timescales agreed with the complainant.

The end of year average was 90%.

Last year the trust achieved an annual figure of 97%.

Data source: Complaints database

The performance of complaint responsiveness reduced during the year due to difficulties largely relating to prison healthcare (see note below). Actions have been taken to address these to bring the service up to the standards of other areas of the trust.

PALS: OUT OF HOURS CALLS

Why was this indicator important to us?
This indicator was used to review the demand for out of hours support and to demonstrate that service users were aware of how to contact us outside normal working hours.

	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10
Evening Calls	262	267	263	280	324	277
Night Calls	146	140	133	213	179	122

	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
Evening Calls	228	249	240	250	278	172
Night Calls	113	136	147	143	164	75

The trust adopted this measure to provide assurance that service users were aware of how to get help outside normal working hours.
Figures have remained relatively constant for the period and for the previous year.

How we compare with others:
The outcome of the patient survey over the last two surveys for the question 'Do you have the number of someone from your local NHS mental health service that you can phone out of office hours?

	2010	2008
Trust performance:	56%	45%
National average:	58%	Not known

Note: A range of actions have been taken during the year to strengthen governance processes and monitoring within the Prison Healthcare service.

Performance against key national priorities

Since attaining foundation trust status and for this financial year, 2010/11, the trust has confirmed continuing compliance with the relevant national mental health indicators and performance thresholds as outlined in Appendix B of Monitor's Compliance Framework.

Table 10: Performance against indicators in Monitor's Compliance Framework

	Monitor Indicators – 2010/11	Monitor Threshold	Score for Non Compliance	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD at Q4
1.	100% of Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital	**95%**	0.5	96.6%	96.4%	98.2%	96.2%	96.9
2.	100% of CPA patients receiving formal review in past 12 months	**95%**	0.5	95.3%	95.07%	95.6%	95.6%	95.6%
3.	Minimising delayed transfers of care - (Excluding social care delays)**	**<7.5%**	1.0	3.8%	3.13%	3.2%	2%	2.9%
4.	Admissions to inpatient services having access to crisis resolution home treatment teams	**90%**	1.0	99.3%	98.5%	99.3%	98.6%	99%
5.	Meeting commitment to serve new psychosis cases by early intervention teams based on trajectories agreed with commissioners.	**95%**	0.5	100%	100%	100%	100%	100%
6.	MHMDS Data completeness - identifiers: NHS number, date of birth, postcode, gender, marital status, GP code and commissioner code.	**99%**	0.5	99.1%	99.3%	99.3%	99.5%	99.5%
7.	Access to healthcare for people with learning disabilities – compliance against six criteria.	**n/a**	0.5	Compliant	Compliant	Compliant	Compliant	Compliant
8.	MHMDS Data completeness - outcomes: • % discharged patients with employment status recorded • % discharged patients with accommodation status recorded • % having HONOS assessment in past 12 months	**50% (introduced from quarter 3)**	0.5	N/A	N/A	78.5%	82.8%	79.6%

*** These figures reflect a higher required standard under a local monitoring methology.*

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

The OSCs were invited to contribute to this report but due to the timing of the requirement and the election programme, they were unable to do so. It is intended that the report will be discussed with the committees as part of their annual programme of work.

Comments and feedback have been received from our lead commissioner, Birmingham East and North Primary Care Trust (BEN PCT) and responded to. A final commentary is still awaited.

Birmingham LINk
Making It Happen!
The Mental Health Action Group Of The Local Involvement Network

Formal response to the Quality Account consultation 2010/11 of Birmingham and Solihull Mental Health Foundation Trust by the Mental Health Action Group (Birmingham LINk)

May 15, 2011

The remit of the Mental Health Action Group

The Mental Health Action Group (MHAG) may comment and respond on the Birmingham and Solihull Mental Health Foundation Trust's Quality Account submission and the systems it has in place to try to ensure the quality of patient experience is monitored and improved inside the dynamic contexts of mental health care. The remit of the MHAG is to co-operate with these aims too.

Patient safety and rising numbers of assaults

Firstly, we have noted the trust is ensuring systems are in place to examine the rise in the number of assaults (most pointedly occurring in 2010). We note these rises have been in the acute inpatient sections of care.

We would also encourage further good feedback on this to the MHAG and a continual place on the clinical governance committee that may be rotated for the inclusion of any of the MHAG co-chairs.

We welcome any mechanism that may aid the deeper shared understanding of why rises in assaults are taking place and hope that at some point where possible (post-crisis) patients could aid to shed more light on this by a special survey methods or some user focused monitoring.

We note particular rises occurred in the Highcroft area and there were large spikes in April, July, and Sept 2010. We would encourage as much study on this subject as possible in order to keep patients safe.

Finally we note there are reports within the community social context of those with serious mental illness that the intended welfare changes - both to services and benefits - are creating tensions in their lives, emotional feelings and thoughts. In this regard we would like trust staff to be able to report any additional social tensions they pick up evidentially that may be adding to the stress of the lives of those who become acute.

As a monitoring group we are able to pass matters of social concern onto parliamentary figures should that become necessary to aid the reflection of politicians.

The use of antipsychotics in dementia

The trust have systems in place to reduce the use of anti-psychotics where it is indicated and in accordance with national guidance. We note and welcome the continuing implementation of that.

YASCC services/Outcome measures

The MHAG note the use of outcome measures on this service and will be looking at these further for interest.

Patient experience/PALS

The MHAG note and would encourage that PALS maintains its analysis of use of the phone line by users. The MHAG note too that the use of additional feedback surveys that are sensitised to units or wards or local patient context are to be welcomed. These types of measures should become opened up for shared view where possible and where confidentiality can be preserved.

Patient care plan sharing with patients

The percentage rises in those patients who are declaring they have been given a written copy (or were offered one) and who believe their views were taken into account in the drawing up of their care plan is encouraging. The MHAG do not underestimate this measure since it also indicates improvements in communications in the staff/patient relationship and builds trust.

Underperformance of the community personality disorder service (CPDS)

There is some concern over the lack of effective user co-ordinator originally planned for the CPDS in 2010. Quite how a supportive network was supposed to form of personality disorder users without better attention to this in 2010 is an area of concern. There have been a carer co-ordinator and carer meetings but that is not enough considering the service level agreement intended far more inclusion of users.

MHAG May 15, 2011

Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 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 2010/11;
- 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 2010 to May 2011
- Papers relating to quality reported to the board over the period April 2010 to June 2011
- Feedback from the commissioners dated (May 26, 2011)
- Feedback from governors dated 25/05/11 and as part of the development process of the report.
- Feedback from LINks dated May 14, 2011
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009. Please refer to the complaints report for 2009/10.
- The 2010 national patient survey
- The 2010 national staff survey

The Head of Internal Audit's annual opinion over the trust's control environment dated June 2, 2011.

CQC quality and risk profiles issued during the period September 2010 to March 2011:

- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the quality accounts regulations) (published at www.monitornhsft. gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at www.monitornhsft.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.

Chairman  Date June 2, 2011

Chief executive  Date June 2, 2011

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

We have been engaged by the Board of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust ("the Trust") to perform an independent assurance engagement in respect of the content of Birmingham and Solihull Mental Health NHS Foundation Trust's Quality Report for the year ended March 31, 2011 (the "Quality Report").

Scope and subject matter

We read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

We read the other information contained in the Quality Report and considered whether it is inconsistent with:

- Board minutes for the period April 2010 to May 2011.
- Papers relating to quality reported to the Board for the period April 2010 to May 2011.
- Feedback from the commissioners.
- Feedback from governors May 25, 2011.
- Feedback from LINks dated May 14, 2011.
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Compliance Regulations 2009, for 2009/10.
- The 2010 national patient survey.
- The 2010 national staff survey.
- The Head of Internal Audit's annual opinion over the Trust's controls environment dated May 20, 2011.
- The Care Quality Commission's quality and risk profile dated March 2011.

We considered the implications for our report if we became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Board of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust as a body, to assist the Board 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, 2011 to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board 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 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- making enquiries of management;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is 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
It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Birmingham

June 3, 2011

our staff, our greatest asset

Our workforce profile

While the people our trust cares for are at the centre of what we do, delivering top quality care and services for them would be impossible without the dedication and commitment of our highly skilled staff.

We recognise that the delivery of high quality services is only possible with our dedication and commitment of our highly skilled and motivated workforce. Our trust continually looks at ways of improving staff working lives through leadership, support and staff benefits.

Derek Tobin, service manager (quality and improvement) is a keen member of our trust's choir.

Workforce profile by staff group and gender 2010/11

Table 11: Workforce profile by staff group and gender 2010/11

Staff group	Female	% of Staff	Male	% of Staff2	Grand total
Admin and clerical	521	83.2%	105	16.8%	626
Allied health professional	4	80%	1	20.0%	5
Ancillary	167	74.6%	57	25.4%	224
Art therapist	5	83.3%	1	16.7%	6
Consultant	35	32.7%	72	67.3%	107
Dietician	6	100%	0	0%	6
Drug worker	42	64.6%	23	35.4%	65
Estates	0	0%	24	100%	24
Gateway worker	11	78.6%	3	21.4%	14
Graduate worker	4	100%	0	0%	4
Manager	80	62%	49	38%	129
Medic	85	49.7%	86	50.3%	171
Medical technical officer	32	82.1%	7	17.9%	39
Nursing assistant	458	69.2%	204	30.8%	662
Nurse	922	68%	434	32%	1356
Occupational therapist	81	86.2%	13	13.8%	94
Pharmacist	9	64.3%	5	35.7%	14
Physiotherapist	13	92.9%	1	7.1%	14
Psychologist	215	81.7%	48	18.3%	263
Scientist	7	38.9%	11	61.1%	18
Senior manager	80	52.6%	72	47.4%	152
Support time recovery worker	26	81.3%	6	18.8%	32
Technical instructor	19	44.2%	24	55.8%	43
Grand total	**2822**	**69.4%**	**1246**	**30.6%**	**4068**

Equality and diversity

We are committed to promoting equality of opportunity for everyone, both in the provision of services and employment of staff. Our trust seeks to provide services and employment in an environment free from discrimination, which benefits from diversity, participation and involvement of staff, service users and their carers.

We recognise that inequalities exist within our society and we are fully committed to looking at ways to remedy this. Our trust will not discriminate directly or indirectly through applying conditions or requirements that cannot be shown to be justified.

It is our policy to treat all job applicants and employees fairly, regardless of race, gender, nationality or national origin, marital status, disability, sexual orientation, age, trade union membership and religious belief.

Furthermore, we monitor and publish the composition of our workforce and introduce positive action if it appears necessary.

Table 12: Trust's ethnic profile 2010/11

	Ethnicity	Trust profile 2011	Birmingham and Solihull population
White	British	54.94%	69.98%
	Irish	3.59%	3.03%
	Other White	2.48%	1.45%
Mixed	White and Black Caribbean	1.28%	1.45%
	White and Black African	0.54%	0.14%
	White and Asian	0.42%	0.59%
	Other Mixed	0.37%	0.42%
Asian or British Asian	Indian	6.10%	5.05%
	Pakistani	2.61%	8.92%
	Bangladeshi	0.52%	1.78%
	Other Asian	1.33%	0.89%
Black or Black British	Black Caribbean	9.19%	4.19%
	Black African	6.34%	0.55%
	Other Black	0.96%	0.51%
Chinese	Chinese	0.25%	0.49%
Other Ethnic Group	Other ethnic group	0.96%	0.57%
Undefined	Not stated	8.16%	0.00%
	Grand total	**100%**	**100%**

Fig 7: Trust's ethnic profile 2011

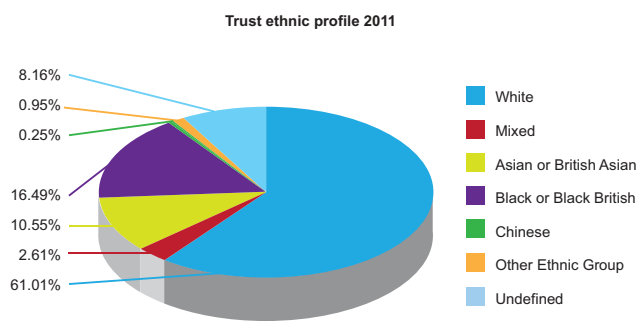


Fig 8: Ethnic profile of Birmingham and Solihull area

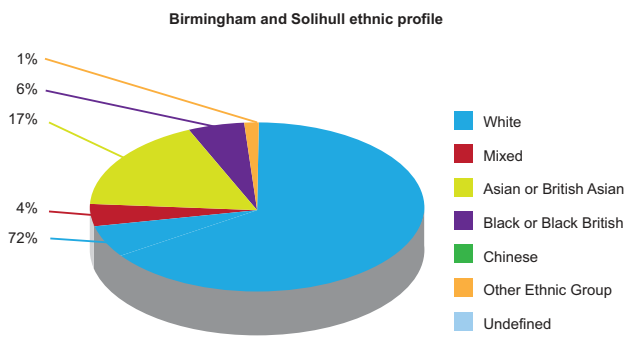


Table 13:
Staff in post: Equality and diversity data 2010/11

Staff in post: Equality and diversity data 2010/11

Gender	10/11	%
Female	2822	69.4%
Male	1246	30.6%
Grand total	**4068**	**100%**

Disability	10/11	%
No	2354	57.9%
Not Declared	31	0.8%
Undefined	1586	39%
Yes	97	2.4%
Grand total	**4068**	**100%**

Age profile	10/11	%
<22	26	0.6%
22-29	470	11.6%
30-39	1074	26.4%
40-49	1342	33%
50-59	930	22.9%
60-65	183	4.5%
65+	43	1.1%
Grand total	**4068**	**100%**

We have maintained the Employment Service's disability 'two ticks' symbol, which recognises our ongoing commitment to recruit and retain staff with disabilities. As an equal opportunities employer we celebrate diversity and operate workforce policies that help us recognise and respond to the individual needs of our staff.

These policies include making sure we accommodate the needs of disabled staff by making reasonable adjustments to their jobs and the working environment so they can continue to work effectively and support the delivery of our services. We also operate recruitment practices that ensure we avoid discrimination and promote best practice.

The chief executive is accountable for the equality and diversity agenda, with lead responsibility for monitoring the delivery of the action plan undertaken by the medical director (operational service delivery issues) and director of organisational development and performance improvement (workforce issues).

The directors of strategic delivery are responsible for ensuring that the equality and diversity agenda is delivered in their divisions.

Single equality scheme
We have developed and published our Single Equality Scheme 2008-2011. This is supported by a detailed action plan setting out targets, outcomes, leads and timescales for focussed action across all of the strands of diversity. The plan is an integral component of our annual plan.

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 ongoing work to harness patient and staff demographic data and to ensure this is provided in a meaningful format. See workforce statistics on tables 12 and 13.

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.

Although we are in the early stages of

implementing a lean approach, 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

Coaching Collaborative

The Coaching Collaborative project was initiated in 2008, bringing together five local NHS organisations, with the sole focus of developing a coaching culture and delivering high quality coaching interventions and raining programmes across partner organisations within the local health economy. The project was funded by the Workforce Locality Stakeholder Board and hosted by the trust.

The Level 3 award in workplace coaching has been established and will have delivered 14 cohorts by the end of the project in October 2011. Level 7 certificate programmes in executive coaching and leadership mentoring have also been successfully delivered.

These coaching interventions have enabled service improvement projects to move forward positively; participants have be able to help staff recognise the need for change and to acknowledge the contribution that they can make to these changes. It is widely recognised that there are many dedicated and talented individuals within the participating organisations and that there is a need to ensure that this talent is retained and developed to become leaders of the future.

The Coaching Collaborative is considering a number of business models to build on this success to ensure that the positive work already undertaken can be sustained in the longer term and developed further. There is a strong commitment to develop the evidence base for coaching interventions within the workplace and to fully evaluate its impact on improving services and the service user experience.

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.org.uk*

BSMHFT moved into a new field of recruitment in 2009/2010 by investing in the recruitment of apprentices into the organisation. As a large employer within Birmingham and Solihull we have a social responsibility to facilitate career opportunities for our local community and also to embrace the government initiative to recruit to the under represented group of 16 to 24 year olds.

Since then the trust has worked with existing staff to encourage a number of individuals to become apprentices giving them the opportunity to undertake training and qualifications which will help them progress to their next role. We also took on a further 11 new recruits. As part of this work an apprenticeship lead has been recruited to ensure that the process for recruiting is as trouble free as possible for managers.

A number of the apprentices were keen to convey how much they have enjoyed the role, below are some quotes from a number of our new workforce:-

Katie Hawkins, business administration apprentice (clinical governance)

"I applied for an apprenticeship because I have always been a hands on sort of girl and for me apprenticeships are perfect because I can learn as well as getting the life experience that I need."

Amie Hinks, business administration apprentice (recruitment)

"I applied for an apprenticeship because I felt it would give me another chance to make a future for myself and give me a career path. As I have been working since I was 14 and never went to college, I needed an option that would allow me to learn new skills as well as earning money."

Chris Cole, IT apprentice

"When I saw the job vacancy online, I knew that this was definitely the place I wanted to apply for. It is a good solid organisation and knew straight away if I was lucky enough to get accepted that I would be on the first step in my career."

Laura Daly, business administration apprentice (Research and development)

"My experience so far has been fantastic, I have a proper role within the trust and play an important part in my team. I am learning something new everyday and have been given an excellent opportunity to gain experience in a business administration role for the trust."

During 2010/11 the trust has continued to recruit to apprenticeship programmes and has taken on four more business and administration apprentices. We are also exploring how the employment of apprentices may be able to support the new Yardley Green development.

From left to right: Amie Hinks (business administration apprentice), Tekisha Shaw (business administration apprentice), Alex Wilson (IT apprentice), Mandy Holland, apprenticeship and work experience programme manager, Katie Hawkins (business administration apprentice, Jessica Barnes (business administration apprentice), and Danny Cooper, business administration apprentice.

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
2010/11 saw the further implementation of our long term People Change Plan. The trust leadership team engaged staff in a series of Big Conversations about the trust's future direction and the challenges posed by the recent changes to the health economy.

These have been followed up by regular site visits by directors to community and inpatient teams where they get to hear about staff concerns and local operating issues first hand. In 2011/12 we will explore further vehicles to engage with staff and garner their views and we will continue to develop the joint problem solving and team-working skills of our managers.

National staff survey 2010

Through the annual NHS staff survey our trust strives to understand staff views and work towards achieving improvements for our staff. In order build on information gathered as part of the annual survey we also use a variety of other methods to understand if we are getting things right for staff, these include: team brief, staff networks, ER forums, electronic staff forum page and the use of on-line staff impressions survey.

While engaging with staff using these various methods, it will support us in understanding staff views and concerns we recognise that we need to continue to develop innovative mechanisms to enable staff to have a voice.

Table 14: Staff survey response rates

	2009/10		2010/11		Trust improvement/ deterioration
Response rate	**Trust**	**National average**	**Trust**	**National average**	
	46%	55%	54%	4%	Increase 8%

Table 15: Staff survey 2010 – top four ranking scores

	2009/10		2010/11		Trust improvement/ deterioration
Top ranking score	**Trust**	**National average**	**Trust**	**National average**	
KF 5: Work pressure felt by staff*	3.06	3.02	2.97	3.01	Positive increase of 0.09%
KF11: Percentage of staff receiving job-relevant training, learning or development in past 12 months	82%	81%	82%	80%	No change
KF8: Percentage of staff working extra hours*	65%	63%	63%	65%	Positive decrease of 2%
KF28: Impact of health and wellbeing on ability to perform work or daily activities*	1.65	1.62	1.61	1.62	Positive decrease of 0.04

Table 16: Staff survey 2010 – bottom four ranking scores

	2009/10		2010/11		Trust improvement/ deterioration
Bottom ranking score	**Trust**	**National average**	**Trust**	**National average**	
KF9: Percentage of staff using flexible working options	No comparative data	–	55%	67%	–
KF38: Percentage of staff experiencing discrimination	No comparative data	–	24%	14%	–
KF27: Perceptions of effective action from employer towards violence and harassment	3.53	3.53	3.41	3.58	Decrease of 0.12
KF26: Percentage of staff experiencing harassment, bullying or abuse from staff in past months*	No comparative data	–	21%	14%	–

*the lower the score the better

The results above indicate that we have significant work to do in addressing our lowest ranking scores within the national survey. The trust remains focused on specifically addressing issues relating to harassment, bullying, physical violence and abuse. We continue to actively promote the role of harassment and bullying advisors who provide confidential advice and support to staff and were initially established following feedback from staff.

We continue to be committed to actively working with all staff, recognising the valuable contribution that they make on a day-to-day basis and also their ability to provide innovative solutions in improving services for both service users. Through the annual survey will strive to actively listen to staff and work towards achieving workplace improvements for staff.

We are continuously reviewing our short and long term approach to addressing issues raised by staff and are committed to achieving measurable improvements.

Volunteer co-ordinator Naomi Hawkins.

Communicating with our staff

New media channels

Since last year, we have been building upon existing communications channels and developing new ways of communicating with staff.

We have launched Connect, the new staff intranet, which will enable information within the trust to be communicated much more effectively, turning it from just an information repository into a powerful communications tool using the latest new media technologies.

Staff will now have the ability to look after their own areas and can upload and edit content accordingly. The new intranet brings many new features meaning information can be accessed more easily and will encourage collaborative working between teams.

An internal electronic bulletin called Bite Size has also been launched, featuring bites of information presented in a user-friendly format to staff.

The Big Conversation

With the changing NHS landscape and the introduction of the Health and Social Care bill, we thought it was important to engage with staff to ensure they are aware of the changes and how it might affect them. The Big Conversation was developed as a platform for staff to ask questions about the future of the trust but also as a way to promote communication between executive directors and staff.

An online staff forum was created to encourage and support discussions around the Big Conversation, but also to enable staff to have queries or rumours they may have heard answered by members of the executive team.

Our staff like to be communicated with face to face, that's why directors embarked on a series of Big Conversation site visits to have an informal chat with staff and answer any queries they may have.

The Big Conversation promotes communication between the executive team and the rest of the trust. It is important that staff feel like they can raise issues and have a platform that can facilitate two-way conversations.

Over the coming year there are some major transformation projects planned and internal communications will be key to the success of these projects.

Listening to and responding to staff is important to us. We will be strengthening internal communications in the coming year and looking at improving communication between all levels of staff.

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 proving assurance that all standards of health and safety legislation are adhered to at all times.

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 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

All of the trust's directors, as listed over the following pages, declare that as far as they are aware, there is no relevant audit information of which the NHS body's auditors are unaware.

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 document entitled *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 subcommittee or otherwise for the purposes of and in accordance with the Mental Health Act 1983, shall be exercised on behalf of the board of directors by the chief executive. The chief executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the board of directors.

The board of directors includes members with a diverse range of skills and experience and backgrounds in both the 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 being undertaken to ensure all members are up-to-date with their skills and requirements.

Professor Peter Marquis – Chairman

Peter was appointed as chairman of the trust in 2007. He has been a non-executive director in the NHS for over 10 years and a member of the trust board since its creation in 2004. Up until his retirement in 2008, Peter was an academic at the University of Birmingham involved in the research and development of materials for joint and tooth replacement.

He was appointed as Professor of Biomaterials in 1991 and subsequently became Head of the School of Dentistry and then Dean of Life and Health Sciences, serving as a member of the university senior management team for over four years. Peter holds a BSc (Hons) in Physics and a Doctorate in Materials Science and is a Fellow of the Institute of Materials, Minerals and Mining.

Interests: Emeritus Professor, University of Birmingham.

Sue Turner – Chief executive

Sue has worked in the NHS for 27 years in a variety of senior management roles, with the past 14 years as chief executive. 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 seen the NHS representative on the steering committee which developed the Government's New Horizon's national mental health strategy.

With a keen interest in personal and organisational development, Sue continues to coach/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 in various blue chip companies including Cable & Wireless, BT Global Services and PriceWaterhouseCooper. She has

a BA (Hons) 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 a chief executive of Wyre Forest District Council, Stan also has wide ranging consultancy experience including work with the Audit Commission, the Office of the Deputy Prime Minister, the Regional Office and with Sport England.

Previous posts held include chairman of governors Kidderminster College, chair of Birmingham Community Resource and Information Service, and chairman of BSMHFT's finance committee.

He has an MSc in management, 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 of the PPI Forum for Birmingham and Solihull Mental Health NHS Trust. 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 CEO 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. He is also a serving magistrate and chair, and was once a deputy director of the Samaritans of Solihull.

He has a BSc in chemistry and an MSc in industrial administration.

Interests: Company director (bookmaking and property), magistrate on Sutton Coldfield Bench.

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 crossborder 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, member of the Chairman's Circle of the Birmingham Symphony and Town Hall, Governor of the King Edward's School Foundation in Birmingham.

Stella Layton – Non-executive director

Stella was appointed as a non-executive director in September 2007. She is European President of Cookson Precious Metals European Division with a turnover of around £200 million, a position she has held since 2001. Cookson Precious Metals is part of the Cookson Group plc, a FTSE registered company.

Stella was the first woman to hold the position of chairperson of the British Jewellers' Association. She is also member of the CBI West Midlands Council, CBI UK Manufacturing Council, CBI Manufacturing Advisory Group.

She has an MBA, and in 2005 was awarded the CBI First Women Award for Manufacturing in its inaugural year. She received an honorary degree of Doctor of Science from Cranfield University in June 2006, and was also finalist in the West Midlands' Business Woman of the Year. She is a guardian of the Birmingham Assay Office and a liveryman of the Worshipful Company of Goldsmiths.

Interests: Cookson Metaux Precious Ltd, Cookson Drijfhourt BV, Cookson Precious Metals Ltd Ireland, CPM UK Ltd, CPM Thailand Ltd, Sempsa Joyeria Plateria, SA, CPM Drijhout Holland, Hallmark Healy UK Ltd, Cookson Clal Ltd.

Dr Peter Lewis – Medical director

Dr Peter Lewis was appointed medical director for Birmingham and Solihull Mental Health NHS Foundation Trust in June 2009. Peter completed his medical training at the University of the West Indies in 1972, then specialised in psychiatry, gaining his FRCP from 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 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 in mental health settings.

Denise's previous senior roles include associate director of operations for a large health economy in the north-west, leading a 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, 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 Chartered Association of Certified Accountants and a member of the Society of Business Recovery Professionals.

Interests: Chief executive – Allegra Limited.

Chris Tidman – Deputy chief executive/executive director of resources

Chris joined BSMHFT as executive director of finance and resources in 2006. Throughout his NHS career, Chris has held a number of directorships and senior management positions within the NHS.

Chris has a wealth of experience in leading on PFI finance, capital investment, business planning and contract development. He holds a first class degree in accountancy and is a member of the Chartered Institute of Management Accountants.

Interests: None declared.

***Chris Tidman left BSMHFT on April 28, 2011.*

The grounds of one trust site, the Uffculme centre, in Moseley.

Board attendance

The table below details attendance to the trust's monthly board of directors meetings, for executive directors and non-executive directors, between April 2010 and March 2011.

Table 17: Attendance at board meetings 2010/11

Execs	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
ST	●	●	●	●	●	●	●	●	●	●	●	●
CT	●	●	●	●	●	●	●	●	●	●	●	●
PL	●	●	●	●	–	●	●	●	●	●	●	●
FA	●	●	●	●	●	●	●	●	●	●	●	●
DR	●	●	●	●	●	●	●	●	●	●	●	–
Non execs												
PM	●	●	●	–	●	●	●	●	●	●	●	●
AL	●	●	●	–	●	●	●	●	●	●	●	●
DB	●	●	●	●	●	●	●	●	●	●	●	●
SB	●	●	●	●	●	●	●	●	●	●	●	●
SL	●	●	–	–	●	●	–	●	–	●	–	●
SSH	–	●	●	–	●	–	●	●	●	●	–	●

Executive directors: ST: Sue Turner; CT: Chris Tidman; PL: Peter Lewis; FA: Frances Allcock; DR: Denise Roach
Non-executive directors: PM: Peter Marquis, AL: Alison Lord; DB: David Boden; SB: Stan Baldwin; SL: Stella Layton; SSH: Sukhbinder Singh Heer.

The trust's community gospel choir sing their hearts out at BBC Choir of the Year Competition.

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 members are our five non-executive directors: Stan Baldwin, David Boden, Sukhbinder Singh Heer (chairman), Stella Layton and Alison Lord.

The committee meets every six weeks, when at least three members of the committee are required to meet.

The 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 to the trust's audit committee meetings, which are held every six weeks, between April 2010 and March 2011. Please note that scheduled meeting for January 27 was cancelled, and rescheduled for February 1.

Execs	Apr	May	July	Aug	Sept	Nov	Dec	Feb	Mar
AL	–	●	●	–	●	–	–	–	●
DB	●	●	●	●	●	●	–	●	●
SB	●	●	●	●	●	–	●	●	●
SL	–	●	–	●	●	–	●	–	–
SSH	●	–	●	●	–	●	●	●	●

Non-executive directors: AL: Alison Lord; DB: David Boden; SB: Stan Baldwin; SL: Stella Layton; SSH: Sukhbinder Singh Heer.

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. The governors are appointed by the members and represent members through a number of constituencies, such as staff governors, stakeholder governors (for example police, local authority) as well public governors appointed from the general membership who may represent patients or carers.

Governors have a number of statutory functions including: appointment and removal of chairman and non executive directors, setting of allowances for chairman and non executive directors, approve the appointment of the chief executive, scrutiny of the annual plan and appointment of the auditors, as well as receiving the annual audit report.

The board of directors comprises both executive and non executive directors, led by the chairman, 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, he or she presides at meetings of the Assembly of Governors and has a casting vote.

Where the chair of the trust has died or has ceased to hold office, or where he/she has been unable to perform their duties as chair, owing to illness or any other cause, the deputy chair shall act up as chair until the existing chair resumes their 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:
within the primary care system;

- To appoint and remove the chair and other non-executive directors of the foundation trust at a general meeting within the primary care system;
- To approve at a general meeting the appointment by the non-executive directors of the chief executive within the primary care system; within the primary care system;
- To appoint or remove the auditor at a general meeting within the primary care system;
- To 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;
- To be presented with the trust's annual report and accounts and the report of the auditor 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 invitation to speak publicly about the trust or their role within it.

For the avoidance of doubt, in this context the chair acts as chair of the trust not as chair of the Assembly of Governors and in his/her absence Governors should seek the advice and views of the deputy chair of the trust acting as the senior independent director.

Nomination and remuneration committee

The governors' nomination and remuneration committee met three times between April 2010 and March 2011. The meetings were held on the dates below:

- June 3, 2010
- November 5, 2010
- March 2, 2011

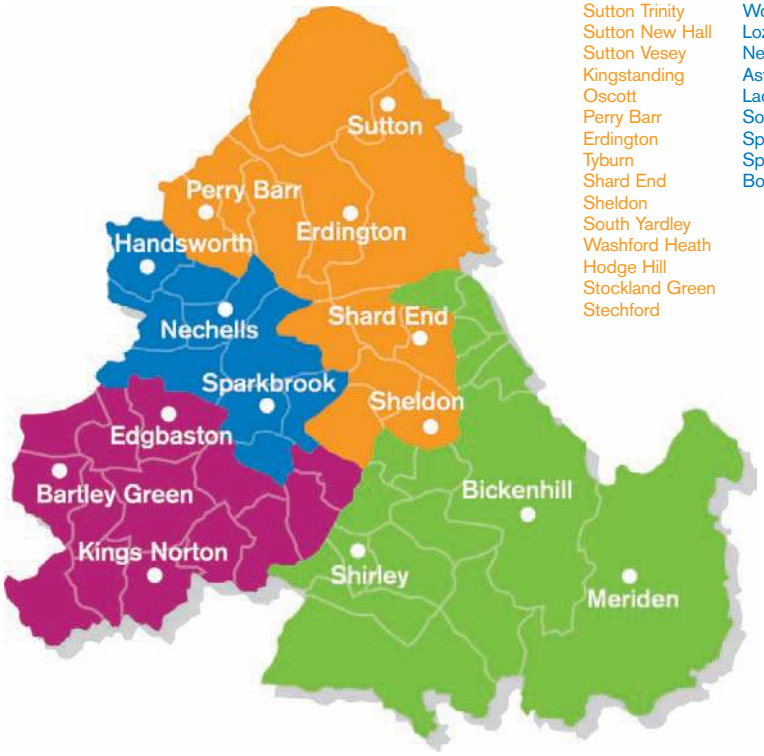
The committee's membership is made up of the trust's chairman and five governors:
Darren Cooper
(Staff governor – nursing)
Committee chairman
Loris Tapper
(Carer governor)
John Robinson
(Service user governor – Birmingham East and North)
Sue Nixon
(Stakeholder governor)
Maureen Johnson
(Public governor – Solihull)

The table above details their attendance to the trust's nomination and remuneration committee meetings, which were held in June, November and March.

Table 19: Attendance at nomination and remuneration committee meetings 2010/11

Committee member	June 1, 2010	November 5, 2010	March 2, 2011
Peter Marquis			
Darren Cooper (chairman)			
Loris Tapper			
John Robinson			
Sue Nixon			
Maureen Johnson			

Map of governor constituencies



Sutton Four Oaks
Sutton Trinity
Sutton New Hall
Sutton Vesey
Kingstanding
Oscott
Perry Barr
Erdington
Tyburn
Shard End
Sheldon
South Yardley
Washford Heath
Hodge Hill
Stockland Green
Stechford

Handsworth
Wood
Lozells East
Nechells
Aston
Ladywood
Soho
Springfield
Sparkbrook
Bordesley Green

Bartley Green
Longbridge
Northfield
Kings Norton
Brandwood
Billesley
Hall Green
Acocks Green
Moseley
Kings Heath
Edgbaston
Harborne
Quinton
Weoley Castle
Selly Oak
Bournville

Dorridge
Hockley Heath
Blythe
Castle Bromwich
Smith's Wood
Kingshurst
Fordbridge
Bickenhill
Meriden
Elmdon
Lyndon
Olton
Solihull
Shirley East
Shirley South
Shirley West
St Alphege
Knowle

Birmingham East and North PCT
Heart of Birmingham PCT
South Birmingham PCT
Solihull Care Trust PCT

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 31 governors across Birmingham and Solihull, comprising of seven from public constituencies, six representing service users, four carers, four representing trust staff and 10 for partner organisations. Each of the four primary care trusts which make up our trust's area – Heart of Birmingham, Birmingham East and North, South Birmingham and Solihull – are each have two public and one service user governor seats. See the map below for how this is configured.

Governors are a key link with the communities the trust serves, who feedback to the board of directors on issues their constituents feel need addressing and ideas for service improvement or development. 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 chairman 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 chairman's/chief executive's contract.

Our governors are now invited to attend monthly board meetings, to increase transparency and involve them in discussions on key issues.

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 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 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 governors through the Foundation Trust Office on 0121 301 1229 or by email to ft.membership@bsmhft.nhs.uk.

Who can become a governor?

- Anyone who is a member of our trust;
- Candidates must be aged 18 or over;
- They must live within the constituency area they wish to represent; and
- Candidates must fit the profile of the vacancy, so only service users can qualify to stand as a service user governor, likewise for carers and public seats.
- All vacancies and notice of elections are published on our website www.bsmhft.nhs.uk.

Our governors

Bishop Dr Joe Aldred
– Public, Birmingham East and North
Khalid Ali
– Public, Rest of England and Wales
Councillor Sue Anderson
– Stakeholder
Peter Brown
– Service user, Solihull
Darren Cooper
– Staff, nursing
Ann Davis
– Stakeholder, University of Birmingham
Patricia Fleetwood-Walker
– Carer
Carl Foulkes
– Stakeholder, West Midlands Police
Elsie Genieve Gayle
– Service user, Rest of England and Wales
Tessa Griffith
– Stakeholder, voluntary sector
Naomi Hawkins
– Staff, non-clinical
Paul Illingworth
– Stakeholder, Birmingham City University
Lawrence Innis
– Carer
Kenneth Jeffers
– Public, Heart of England
Maureen Johnson
– Public, Solihull
Lynne Jones MP
– Stakeholder
Dr Asaf Khan
– Staff, clinical
Peter Lea
– Stakeholder, Solihull Metropolitan Borough Council
Ann McKenzie
– Carer
Jane Morel
– Stakeholder, Terrence Higgins Trust
Bernadette Murray
– Public, South Birmingham
Vinodrai Mehta
– Staff, other clinical
Gerry Moynihan
– Public: Heart of Birmingham
Sue Nixon
– Stakeholder, PCT commissioners
Renganathan Ramamoorthy
– Public, Birmingham East and North
Sally Selvey
– Staff, nursing
Brian Sheppard
– Public, Solihull
Lynda-Jane Smith
– Service user, South Birmingham
Loris Tapper
– Carer
Faheem Uddin
– Service user, Heart of Birmingham
Dr Charles Zuckerman
– Stakeholder: Local medical committee

Ann McKenzie, a carer governor, and our chairman Peter Marquis at our Maple Leafg Drive unit.

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 over issues 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.

Attendance at Assembly of Governors meetings 2010-11

The table below shows attendance at Assembly of Governors meetings between April 1, 2010 and March 31, 2011.

Table 20:Attendance at Assembly of Governors meetings 2010-11

GOVERNORS	26th May 2010 (Annual Plan Meeting)	3rd June 20109th	September 2010	9th December 2010	10th March 2011	Interests
Bishop Joe Aldred	●	●	●		●	
Councillor Sue Anderson				●	●	
Darren Cooper		●	●			Interests in matters relating to Sandwell Council
Professor Ann Davis		●	●		●	
Sue Nixon		●		●	●	Role with the commissioners
Lawrence Innis	●		●	●	●	
Kenneth Jeffers				●		
Dr Lynne Jones	●	●	●	●	●	
Dr Asaf Khan	●	●	●	●		
Vinod Mehta			●	●	●	
Bridie Nugent	●	●	●	●	●	
Renganathan Ramamoorthy		●	●			
John Robinson	●	●	●			
Chief Superintendent Carl Foulkes						
Sally Selvey		●			●	
Lynda Smith		●		●	●	
Loris Tapper	●	●	●	●	●	
Faheem Uddin		●		●	●	
Charles Zuckerman					●	
Peter Brown	●	●	●	●	●	
Brian Sheppard		●	●	●	●	
Anne McKenzie		●	●	●		
Jane Morel		●	●	●	●	
Khalid Ali				●		
Naomi Hawkins	●		●		●	
Councillor Peter Lea	●	●	●		●	
Maureen Johnson	●	●	●	●	●	
Elsie Gayle		●	●	●	●	Member of Birmingham LINk and and sits on three groups for this organisation
Paul Illingworth			●		●	
Tessa Griffiths		●	●	●	●	
Patricia Fleetwood-Walker			●	●		
(Gerry Moynihan)	●					

DIRECTORS	26/5	3/6	9/9	9/12	10/3
Peter Marquis: Chairman	●	●	●	●	●
Sue Turner: Chief executive	●	●			
Frances Allcock: Executive director of organisational development and performance	●	●		●	●
Stan Baldwin: Non-executive director	●				
David Boden: Non-executive director	●	●		●	●
Sukhbinder Singh Heer: Non-executive director	●	●			●
Stella Layton: Non-executive director	●				
Peter Lewis: Medical director		●	●		
Alison Lord: Non-executive director	●				●
Chris Tidman: Executive director of resources/Deputy chief executive	●		●		
Dee Wilson: Executive director of quality, improvement and patient experience	●	●		●	

A busy year for our governors

Governors are increasingly more involved in our services and their input is always a valued one.

Governors are invited to discuss the annual plan and to comment on the trust's strategic direction, whether that is through formal meetings, ad-hoc seminars or one-to-one meetings with the chairman.

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, members were invited to take a stroll with the governors round the canals of Birmingham to talk and walk through any concerns that they felt needed raising. Governors have also attended our member seminars, which is a great way for them to engage with both staff and members regarding interesting issues around mental health.

Governors also play an active role in the procurement of trust tenders. Our service user governors have had a lot of involvement with our estates and facilities team, and have helped them not only with some tenders, but with other activities such as the 2011 Patient Environment Action Team (PEAT) Inspections. These inspections entailed services user governors accompanying the estates and facilities team when inspecting the cleanliness and safety of patient areas throughout our trust.

David Evans, senior facilities and hotel service manager said: 'During the PEAT inspections we had the pleasure of the service user governors joining our team. I was so happy with the input they each gave to the discussions during and after the individual inspections. I also personally gained important new knowledge from the governors that would assist me in my efforts to improve patient services in BSMHFT. The governors helped me understand the service users' position a lot clearer, what they require and how we can improve services for them.'

directors' report

Principal activities

BSMHFT provides 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 more than 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

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, Secure and Complex Care (YASSC); Mental Health Services for Older People (MHSOP), 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 plan of care which suits each individual person and offers different types of support including community, inpatient, outpatient and day services.

We have worked, and will continue to work, hard to support and improve the mental health of people across our patch through a range of locally based inpatient and community services.

We 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 section of this annual report entitled Our staff, our greatest asset, which begins on page 50.

Information governance incidents

There were a total of nine information governance Incidents for the financial year 2010/2011, which illustrates how rare these can be, especially in a trust as large as ours. Of these four were in Mental Health Services for Older People, three were in Youth, Addictions, Secure and Complex Care, and two were in Adults of Work Age division.

These included:

- Loss of a dictation tape containing information relating to service users seen by a consultant psychiatrist (April 2010).
- Loss of care records during transport. The notes were subsequently handed in by a member of the public.

The other incidents were not considered to be as serious as they were near misses, the fault of the service user or simply downgraded to an IRIS following investigation.

Summary financial accounts

This section provides a commentary of our trust's financial performance for financial year 2010/11. It provides an overview of our income, expenditure, cashflows and capital expenditure in the year. We ended the year with an operating surplus of £3.5 million before exceptional items, leading to a financial risk rating of 4 from Monitor. This equates to a score of excellent 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 organization including both the cashflows and income and expenditure position.

Financial performance

This has been another challenging year for the trust particularly in light of the current financial climate and growing pressure on public finances. An operating surplus of £3.5m was made excluding exceptional items. Exceptional items included the reduction in the value of our estate of £2.7m and the cost of restructuring our services of £2.6m. Services across the trust worked hard in the year to manage expenditure and to achieve the £7m savings target required to ensure that the financial plans were met. Our pay and non pay expenditure held fairly constant and this along with delivery of our income targets ensured a relatively stable position during the year.

We were pleased that during the year we received approval for funding from the Foundation Trust Financing Facility for a £33m loan to build a new men's medium secure unit at Yardley Green. The decision was delayed due to the general election but work has now commenced and we expect to open to admissions from December 2012.

The delivery of a surplus over recent years has been key in delivering our plans and ensuring the financial stability of the trust. In 2010/11, this has included the Juniper development and continued investment in our estate. The surplus has also allowed us to invest in improving the quality of our services and patient experience.

In 2010/11 we have invested in a range of developments including:

- Implementation of an E-rostering solution;
- investment in our people change programme;
- patient feedback mechanisms;
- implementation of an electronic care record; and
- continued development of the IT infrastructure including remote access for staff.

Income and expenditure

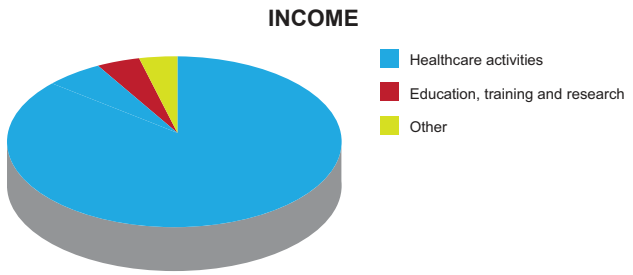
Table 21: Income and expenditure 2010/11 and 2009/10

	2010/11 £000	2009/10 £000
Income from activities	208,359	204,016
Other operating income	17,560	18,680
Total income	225,919	222,696
Operating expenses	-214,488	-209,326
EBITDA	11,431	13,370
Depreciation	-4,284	-4,270
Impairments	-2,690	-13,206
Profit/loss on asset disposal	0	57
Interest received	156	112
Interest payable	-4,131	-3,541
Public dividends payable	-2,237	-2,783
Surplus /(deficit) including exceptional items	-1,755	-10,261
Exceptional items:		
Impairments	-2,690	-13,206
Costs of restructuring	-2,599	-712
Operating surplus excluding exceptional items	3,534	3,657
Income and expenditure surplus margin	1.50%	1.60%
EBITDA Margin	5.10%	6.00%

** EBITDA – earnings before interest, tax, depreciation and amortisation*

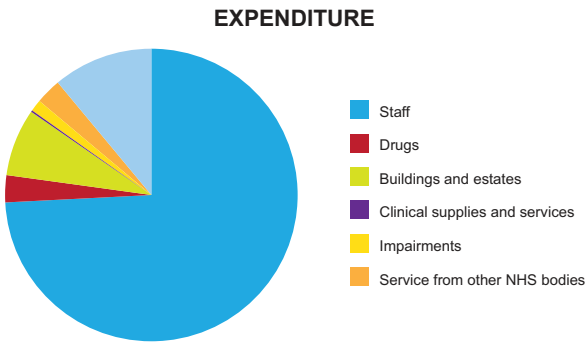
In the financial year 2010/11 the trust generated income totalling £226 million. A breakdown of this income is detailed in the chart below:

Figure 9: Where our income comes from



92 per cent of our income 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 four per cent of our total income.

Figure 10: How our total expenditure is split



It can be seen that staffing is our most valuable and expensive resource. However, we also operate from over 100 sites across Birmingham and Solihull meaning premises costs are a major cost driver.

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 2010/11 our trust has a cash balance of £33.6million 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 £19m in improving our assets this year. The largest scheme was the Juniper centre, our new unit for mental health services for older people. The total value of the scheme was £16.3m and this was funded through a loan from the Foundation Trust Financing Facility.

Other schemes included improvements to inpatient facilities at Mary Seacole; preparatory work for the Yardley Green site; and a range of smaller schemes to improve the environment, ensure compliance with statutory standards and IT infrastructure. We also invested in a new electronic care record system which will go live in 2011/12.

Due to the changing economic climate, we have reviewed the value of our entire estate. This has resulted in an adjustment to reduce the value of our buildings by £2.7 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 www.dh.gov.uk/PolicyAndGuidance/OrganisationalPolicy/FinanceAndPlanning/NHSManagementCosts/fs/en

The management costs for the year were £13.1 million, which represents 5.8 per cent of income.

External audit

The trust's Assembly of Governors appointed PricewaterhouseCoopers LLP as its external auditor during the year 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 that 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 ensured that the auditors are aware of the information.

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 the 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 the target is summarised in the table below:

Table 22: Performance against payment targets 2010/11 and 2009/10

	2010/11 Number	£000	2009/10 Number	£000
Total NHS invoices paid in the period	713	11,704	794	9,820
Total NHS invoices paid within target	664	11,091	760	9,413
Percentage of NHS invoices paid within target	93%	95%	96%	96%
Total non-NHS invoices paid in the period	32,662	60,018	33,535	52,073
Total non-NHS invoices paid within target	30,420	57,045	30,971	50,368
Percentage of non-NHS invoices paid within target	93%	95%	92%	97%

We paid no interest during the year under the late payment of commercial debts (interest) Act 1998.

Looking forward

We expect the coming year to be more difficult due to the continued pressure on budgets as a result of the economic climate. We need to deliver savings of four per cent, higher than we have ever achieved before and this is our biggest risk in 2011/12. This will mean close working with our commissioners to identify where savings can be made and to understand how this will impact on our services.

In the year we are planning to devolve more responsibility to our frontline staff for managing budgets. We believe that this will improve accountability and financial control and supports the changes we are making to our organisation.

We will continue with our investments where we believe that it will improve the quality of our services and help to deliver future efficiencies. Therefore in 2011/12 we plan to take forward a number of developments including:

- Development of a male medium secure unit on the Yardley Green site;
- Implementation of an electronic care record; and
- Further investment in our IT infrastructure.

We recognise the scale of investment and of borrowing does mean that we have reduced our flexibility in the short term, in particular with regards to our cash position. The board has made this decision as it believes it is in line with our strategic goals and recognises the risks associated with this. We have developed mitigation strategies to minimise the impact of these risks.

We are assessing how the changes in Government policy may 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 work to begin 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 millions of pounds.

The situation is improving year on year as recovery of money, prosecution of offenders and awareness of the issue continue 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 amongst trust staff, reducing the risk of fraud through a programme of proactive work and, in the event of a suspicion being raised, conducting formal investigations.

To find out more contact one of the trust's LCFS. Contact: David Fletcher email DCFletcher@deloitte.co.uk or call 0121 695 5162.

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 page [X] of the remuneration report

The NHS foundation trust has complied with the cost allocation and charging requirements set out in 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 Summerhill Road,
Birmingham, B1 3RB.

Statement of the chief executive's responsibilities

as the accounting officer of Birmingham and Solihull 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.

Chief executive  Date: June 2, 2011

Statement on internal control 2010/11

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 trusts 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 31 March 2011 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, infection control, local security management (NHS SMS), safeguarding children, safeguarding vulnerable adults and complaints).

The medical director and the director of quality, improvement and patient experience (director of nursing) 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/deputy chief executive had responsibility for managing the development, implementation and management of financial control and IM&T systems. The trust's finance committee plays a key role in managing financial risk and in ensuring that resources are deployed economically and effectively. The deputy chief executive also chaired the performance management and improvement board, ensuring that performance across a range of quality and productivity metrics was monitored and delivered, and that action plans were in place to address any identified weaknesses.

The executive director of organisational development and performance improvement delegated responsibility for managing risks associated with the recruitment, retention, training and development and remuneration of our workforce.

The director of commercial services and asset management had overall responsibility for the trust estate, plant, waste management, fire safety, environmental management and major incident planning.

Three directors of strategic delivery delegated responsibility for managing operational risk across their divisions.

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

The trust learns from good practice through a range of mechanisms including 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.

Each director is accountable overall for informing the trust risk register in relation to risks relating to their overall executive responsibilities.

The risk and control framework

The risk management strategy clearly 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 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 ethos is 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.

There are formal mechanisms in place to ensure that external changes to best practice, such as those issued by the National Institute for Health and Clinical Excellence, are incorporated into trust policies procedures and clinical guidelines.

Data security risks

The trust monitors and manages its information governance (IG) compliance through the IG assurance framework reporting up to the information governance steering group (IGSG) which is chaired by the senior information risk owner (SIRO)/Director of information and communications technology 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 organizational 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 ongoing and extremely important process in ensuring staff are aware of their responsibilities, as detailed in these documents.

In response to a number of national issues around breaches in patient confidentiality, the information governance committee has endorsed a policy to mitigate the risks around data security, and data loss. We had one serious data security incident during the year relating to a stolen laptop, which contained both confidential patient and staff data on its hard drive. Despite being password controlled, the laptop had not been encrypted. We have liaised with the Information Commissioner's Office (ICO) to ensure we have followed best practice when contacting those affected. We have also given a written undertaking to the ICO with regards to preventing a re-occurrence and have initiated an urgent project to encrypt all remaining laptops.

The major risks identified by the trust are as follows:

In year risks

The trust has recognised the risk of maintaining continued compliance with Care Quality Commission (CQC) regulations. The complexities of the prison healthcare service and its environment have provided significant challenges. Compliance overall is reviewed through the trust clinical governance processes and actions identified where gaps or weaknesses are identified.

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.

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. All notified risks are then validated by the trust's risk management team to ensure consistency. All divisional risks rated at 12 or over are captured on the trust risk register and further escalation is defined for higher levels of risk.

The trust has developed a clinical quality dashboard approach to systematically focus on areas of key clinical risk. The trust's clinical governance committee has continued to focus on exceptions, trends and lessons learned.

The trust's risk management committee regularly reviews local risk registers from individual clinical programmes to ensure that these are maintained and accurately reflect risks at the clinical interface.

The trust's 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.

Managing risks with public stakeholders

There are robust 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 (eg strategic partnership boards). The trust will endeavour to involve partner organisations in all aspects of risk management.

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 is developed via the strategic risk management committee (which consists of 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.

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The foundation trust is not fully compliant with the requirements of registration with the Care Quality Commission

The CQC undertook a responsive review in February 2011. As a result of the review, the CQC made recommendations in relation to five of the standards. These were moderate concerns relating to four standards and a major concern relating to safeguarding people who use services from abuse. Actions have been agreed to address these concerns by the end of June 2011. These include:

- Strengthening the trust's safeguarding procedures and ensuring staff awareness,
- improving understanding and awareness of Deprivation of Liberty Safeguards (DOLS), and
- to improve procedures to ensure all potentially notifiable incidents are correctly coded.

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 organisations 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 2010/11 has meant that we were able to achieve a risk rating of '4' demonstrating that we have been able to manage our resources effectively. We have achieved this after investing in key areas, including our estate, IT infrastructure and a new electronic care record, which we believe will support our staff to deliver services and to generate future efficiencies. Despite a challenging savings target of 3.5 per cent we have managed to deliver this on a recurring basis.

The Head of Internal Audit Opinion for 2010/11 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.

We have implemented a range of electronic procurement systems during the year to facilitate ordering and the tendering and quotation processes. This has allowed the trust to achieve savings through procuring from a range of suppliers.

Due to the significant spend on temporary staffing we have implemented an electronic rostering system to assist our ward managers in optimising the use of our nursing resources.

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 to prepare quality reports 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 account have been an integral part of the routine clinical governance processes over the year. All 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 details 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 also been subject to a wider consultation process involving staff, Assembly of Governors, patient and carer groups and commissioners.

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 board reviews and agrees the assurance framework which is informed by the wider risk management processes.

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,
- annual programme of risk assessments, and
- reviews against regulation requirements.

Conclusion

As accounting officer I can confirm that the trust has a sound system of internal control that supports the achievement of the organisations plans, aims and objectives.

The trust has identified actions in relation to concerns raised by the CQC as part of its responsive review and is confident that these can be addressed by the end of June 2011.

I can confirm that this statement on internal control is a balanced reflection of the systems in place during 2010/11.

Chief executive

Date: June 2, 2011

Remuneration report

The information in this section is not subject to audit

Nominations and remuneration committee

The committee members are:

- The chairman of the committee;
- the trust chairman; and
- four non-executive directors.

The nominations and remuneration committee of our trust is a sub-committee of the trust 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 twice during 2010/11 and is chaired by Stella Layton.

Table 23: Attendance at nomination and remuneration committee

Execs	Meeting 1	Meeting 2
PM	Y	Y
AL	Y	
DB	Y	Y
SB	Y	Y
SL		Y
SSH	Y	Y

Non-executive directors: PM: Peter Marquis; AL: Alison Lord; DB: David Boden; SB: Stan Baldwin; SL: Stella Layton; SSH: Sukhbinder Singh Heer.

The work of the committee in this year was:

- To review remuneration of senior executive directors, including the chief executive.
- To approve the guidelines for the remuneration for the recruitment of two executive directors - executive director of organisational development and performance, and executive director of quality, improvement and patient experience, and provision of the members of the interview and appointments panels for these two posts.

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.

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 an 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 in their contracts.

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

Table 24: Contract terms for non-executive directors

Name and title	Date of first appointment	Notice Period	Unexpired term of the contract at March 31, 2011
Peter Marquis (Chairman)	07/09/2007	1 month	5 months
Stella Layton (Non-executive director)	01/03/2008	1 month	11 months
Sukhbinder Heer (Non-executive director)	13/08/2007	1 month	5 months
Alison Lord (Non-executive director)	01/09/2007	1 month	5 months
Stan Baldwin (Non-executive director)	01/05/2003	1 month	1 month
David Bowden (Non-executive director)	12/10/2006	1 month	Expired

Sue Turner
Chief executive

June 2, 2011

The information in this section is subject to audit

Table 25: Salary and pension entitlements of senior managers – salaries and allowances

Name and Title	Year ending 31 March 2011			Year ending 31 March 2010		
	Salary (Bands of £5,000) **£'000**	**Other remuneration** (Bands of £5,000) **£'000**	**Benefits in kind** (rounded to nearest £100) **£**	**Salary** (Bands of £5,000) **£'000**	**Other remuneration** (Bands of £5,000) **£'000**	**Benefits in kind** (rounded to nearest £100) **£**
Sue Turner (Chief executive officer)*	170-175	–	–	190-195	–	–
Chris Tidman (Deputy CEO / Executive director of resources) (resigned April 27, 2011)	135-140	–	–	125-130	–	–
Peter Lewis (Executive medical director) (appointed June 1, 2009)	100-105	60-65	–	100-105	55-60	–
Frances Allcock (Executive director of organisational development and performance Improvement) (appointed February 1, 2010)	120-125	–	–	20-25	–	–
Denise Roach (Executive director of quality, improvement and patient experience) (appointed February 1, 2010)	100-105	–	5,900	15-20	–	–
Peter Marquis (Chairman)	40-45	–	–	40-45	–	–
Stella Layton (Non-executive director)	10-15	–	–	10-15	–	–
Sukhbinder Heer (Non-executive director)	10-15	–	–	10-15	–	–
Alison Lord (Non-executive director)	10-15	–	–	10-15	–	–
Stan Baldwin (Non-executive director)	10-15	–	–	10-15	–	–
David Bowden (Non-executive director)	15-20	–	–	10-15	–	–
Karen Martin (Director of organisational and workforce development) (resigned October 31, 2009)				70-75	–	–
Ros Alstead (Director of nursing) (resigned October 31, 2009)				60-65	–	–
Neil Deuchar (Medical director) (resigned May 31, 2009)				15-20	5-10	–

Table 26: Pension benefits 2010/11

Name and Title	Real increase in pension at age 60 in pension (Bands of £2,500) £'000	Lump sum at age 60 related to real increase 2100 (Bands of £2,500) £'000	Total accured pension at age 60 ending 13 March at 31 (Bands of £5,000) £'000	Lump sum age 60 related to accrued pension (Bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2011 £'000	Cash Equivalent Transfer Value at 31 March 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	1,037	1,115	(-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)	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)	5-10	25-27.5	25-30	80-85	355	292	63

Table 27: Pension benefits 2009/10

Name and Title	Real increase in pension at age 60 in pension (Bands of £2,500)	Lump sum at age 60 related to real increase 2100 (Bands of £2,500)	Total accured pension at age 60 ending 13 March at 31 (Bands of £5,000)	Lump sum age 60 related to accrued pension (Bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2011	Cash Equivalent Transfer Value at 31 March 2010	Real increase in accrued pension during year
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Sue Turner (Chief executive officer) *	2.5-5	12.5-15	55-60	170-175	1,115	932	136
Chris Tidman (Deputy CEO / executive director of resources) (resigned April 27, 2011)	2.5-5	7.5-10	25-30	85-90	393	326	59
Peter Lewis (Executive medical director) (appointed June 1, 2009)	0-2.5	5-7.5	10-15	40-45	–	–	–
Frances Allcock (Executive director of organisational development and performance improvement) (appointed February 1, 2010)	0-2.5	0-2.5	0-5	0-5	4	–	–
Denise Roach (Executive director of quality, improvement and patient experience) (appointed February 1, 2010)	0-2.5	0-2.5	15-20	55-60	292	235	7
Karen Martin (Director of organisational and workforce development) (resigned October 31, 2009)	0-2.5	5-7.5	40-45	130-135	762	642	51
Ros Alstead (Director of nursing) (resigned October 31, 2009)	0-2.5	0-2.5	40-45	125-130	865	760	39
Neil Deuchar (Medical director) (resigned May 31, 2009)	0-2.5	0-2.5	25-30	80-85	562	500	6

Ill health retirements

During the year there were seven early retirements due to ill health. The costs of these are borne by the NHS Business Services Authority – Pensions Division. The value of these early retirements was £785,000.

Independent Auditors' Report to the Board 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 31 March 2011 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 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. 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 Board of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Scope of the audit of the financial statements
An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Foundation Trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report 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, of the state of the NHS Foundation Trust's affairs as at 31 March 2011 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.

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
- 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 Statement on Internal Control does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 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 Accounting Officer's Statement on Internal Control addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources;
- we have qualified our report on any aspects of the Quality Report.

Certificate
We certify that we have completed the audit of the accounts 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, Birmingham

June 3, 2011

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 & SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

ANNUAL ACCOUNTS

31 MARCH 2011

Statement of Comprehensive Income

	note	Year ending 2010/11 £000 PRE EXCEPTIONAL ITEMS	Year ending 2010/11 £000 EXCEPTIONAL ITEMS	Year ending 2010/11 £000 TOTAL	Year ending 2009/10 £000 PRE EXCEPTIONAL ITEMS	Year ending 2009/10 £000 EXCEPTIONAL ITEMS	Year ending 2009/10 £000 TOTAL
Operating Income	2	225,919	–	225,919	222,696	–	222,696
Operating Expenses	4	(216,173)	(5,289)	(221,462)	(212,827)	(13,918)	(226,745)
OPERATING SURPLUS/(DEFICIT)		9,746	(5,289)	4,457	9,869	(13,918)	(4,049)
FINANCE COSTS							
Finance income	7	156	–	156	112	–	112
Finance expense - financial liabilities	8	(4,131)	–	(4,131)	(3,541)	–	(3,541)
PDC Dividends payable		(2,237)	–	(2,237)	(2,783)	–	(2,783)
NET FINANCE COSTS		(6,212)	–	(6,212)	(6,212)	–	(6,212)
SURPLUS/(DEFICIT) FOR THE YEAR		3,534	(5,289)	(1,755)	3,657	(13,918)	(10,261)
Other comprehensive income/(expense)							
Revaluation gains/(losses) and impairment losses property, plant and equipment				618			(6,666)
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets				(68)			(62)
TOTAL COMPREHENSIVE (EXPENSE) FOR THE PERIOD				(1,205)			(16,989)

All activities are from continuing operations

Birmingham & Solihull Mental Health NHS Foundation Trust
31 March 2011

Statement of Financial Position

	note	31 Mar 2011 £000	31 Mar 2010 £000
Non-current assets			
Intangible assets	9	–	–
Property, plant and equipment	10	178,368	165,169
Trade and other receivables	12	1,525	1,172
Total non-current assets		**179,893**	**166,341**
Current assets			
Inventories	11	305	460
Trade and other receivables	12	6,648	4,695
Cash and cash equivalents	21	33,613	32,097
Total current assets		**40,566**	**37,252**
Current liabilities			
Trade and other payables	13	(23,248)	(18,655)
Borrowings	15	(1,720)	(2,060)
Provisions	18	(3,696)	(919)
Other liabilities	14	(9,404)	(10,625)
Total current liabilities		**(38,068)**	**(32,259)**
Total assets less current liabilities		182,391	171,334
Non-current liabilities			
Borrowings	15	(83,647)	(71,512)
Provisions	18	(1,021)	(894)
Total non-current liabilities		**(84,668)**	**(72,406)**
Total assets employed		**97,723**	**98,928**
Financed by (taxpayers' equity)			
Public Dividend Capital		100,067	100,067
Revaluation reserve		20,879	20,441
Donated Asset Reserve		1,996	1,884
Income and expenditure reserve		(25,219)	(23,464)
Total taxpayers' equity		**97,723**	**98,928**

The financial statements on pages 2 to 5 and the associated notes were approved by the Board on 2nd June 2011 and signed on its behalf by:

Signed:  (Chief executive)

Date: June 2, 2011

Birmingham & Solihull Mental Health NHS Foundation Trust
31 March 2011

Statement of Changes in Taxpayer's Equity

	Total	Public Dividend Capital	Revaluation Reserve	Donated Assets Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2010	**98,928**	**100,067**	**20,441**	**1,884**	**(23,464)**
Surplus/(deficit) for the year	(1,755)	–	–	–	(1,755)
Revaluation gains/(losses) and impairment losses property, plant and equipment	618	–	438	180	–
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets	(68)	–	–	(68)	–
Public Dividend Capital received	–	–	–	–	–
Other transfers between reserves	–	–	–	–	–
Movements on other reserves	–	–	–	–	–
Taxpayers' Equity at 31 March 2011	**97,723**	**100,067**	**20,879**	**1,996**	**(25,219)**
Taxpayers' Equity at 1 April 2009	**115,877**	**100,027**	**27,048**	**2,092**	**(13,290)**
Surplus/(deficit) for the year	(10,261)	–	–	–	(10,261)
Revaluation gains/(losses) and impairment losses property, plant and equipment	(6,666)	–	(6,520)	(146)	–
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets	(62)	–	–	(62)	–
Transfers to the income and expenditure account in respect of assets disposed of	–	–	(87)	–	87
Public Dividend Capital received	40	40	–	–	–
Other transfers between reserves	–	–	–	–	–
Movements on other reserves	–	–	–	–	–
Taxpayers' Equity at 31 March 2010	**98,928**	**100,067**	**20,441**	**1,884**	**(23,464)**

Statement of Cash Flows

	note	2010/11 £000	2009/10 £000
Cash flows from operating activities			
Operating surplus/(deficit) from continuing operations		**4,457**	**(4,049)**
Operating surplus/(deficit) of discontinued operations		–	–
Operating surplus/(deficit)		**4,457**	**(4,049)**
Non-cash income and expense:			
Depreciation and amortisation		4,284	4,270
Impairments		2,690	13,206
Transfer from the donated asset reserve		(68)	(62)
(Increase)/Decrease in Trade and Other Receivables		(2,169)	3,128
(Increase)/Decrease in Inventories		155	64
Increase/(Decrease) in Trade and other Payables		3,437	3,332
Increase/(Decrease) in Other Liabilities		(1,221)	4,951
Increase/(Decrease) in Provisions		2,904	505
Tax (paid) / received		115	153
NET CASH GENERATED FROM/(USED IN) OPERATIONS		**14,584**	**25,498**
Cash flows from investing activities			
Interest received		156	112
Purchase of Property, Plant and Equipment		(18,362)	(10,834)
Sales of Property, Plant and Equipment		–	312
Cash flows attributable to investing activities of discontinued operations		–	–
Net cash generated from/(used in) investing activities		**(18,206)**	**(10,410)**
Cash flows from from financing activities			
Public dividend capital received		–	40
Public dividend capital repaid		–	–
Loans received		13,790	5,300
Capital element of Private Finance Initiative Obligations		(2,060)	(2,035)
Interest paid		(463)	(54)
Interest element of Private Finance Initiative obligations		(3,603)	(3,473)
PDC Dividend paid		(2,526)	(2,631)
Net cash generated from/(used in) financing activities		**5,138**	**(2,853)**
Increase/(decrease) in cash and cash equivalents		**1,516**	**12,235**
Cash and Cash equivalents at 1 April		32,097	19,862
Cash and Cash equivalents at 31 March		**33,613**	**32,097**

1 Accounting policies and other information

1.1 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 2010/11 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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.

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.

1 Accounting policies and other information (continued)

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-balance sheet 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.

Donated assets
Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the Statement of Comprehensive Income. Similarly, any impairment on donated assets charged to the Statement of Comprehensive Income is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

"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-balance sheet' 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.

1 Accounting policies and other information (continued)

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.

1.7 Intangible assets
Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

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

1 Accounting policies and other information (continued)

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. 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. Grants from the Department of Health, including those for achieving three star status, are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

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.

1.10 Financial instruments and financial liabilities
Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made. Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below. Regular purchases or sales are recognised and de-recognised, as applicable, using the Settlement date. All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cashflows 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.

1 Accounting policies and other information (continued)

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 balance sheet 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 cashflows 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.

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% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% 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 Accounting policies and other information (continued)

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%) 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.

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

Most of the activities of the NHS Foundation Trust are outside the scope of Corporation Tax. Application of Corporation Tax to NHS bodies has been deferred beyond 31 March 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 performance:

• monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;

• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and

• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the balance sheet 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 2011/12.

– 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.

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 2009/10 and 2010/11, 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 (e.g. 'Fair Value through Profit and Loss', Loans and Receivable etc). It is applicable from 2011/12. 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 24 (Revised) - Related Party Disclosures

This new standard seeks to reduce the extent of disclosures required by government entities whose transactions are principally with other government entities. It is due for adoption in 2011/12. This may potentially relieve NHS bodies from providing some of its related party disclosures with other entities within the Whole of Government Accounts boundary, unless HM Treasury chooses to adapt the standard to retain the existing disclosures.

iv) IASB Annual Improvements 2010

The document makes minor changes to 6 standards and one IFRIC Interpretation. Three of the standards IFRS 1 First time adoption of IFRS, IAS 34 Interim financial reporting and IFRIC 13 customer loyalty programmes are not relevant to NHS bodies.

The amendments to IAS 1 presentation of financial standards, IAS 27 consolidated and separate financial statements, IFRS 3 business combinations and IFRS 7 financial instrument – disclosures are minor in nature and should have little or no impact for NHS bodies.

v) IFRIC 14 - IAS 19-The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their Interaction

This is an amendment to the IFRIC that applies from 2011/12. There will be no impact on most NHS bodies as they are not members of a defined benefit scheme that is accounted for as such. It will have no immediate impact on those bodies which are members of a defined benefit scheme as most local government schemes are in deficit rather than in surplus.

vi) IFRIC 19 - Extinguishing financial liabilities with equity instruments

This new IFRIC applies from 2011/12 but will have no impact because NHS bodies have no equity instruments and therefore cannot issue them to settle financial liabilities.

b) Government Financial Reporting Manual (FReM) changes

The following changes to the HM Treasury FReM are potentially applicable to NHS bodies from 2011/12.

i) Treatment of grants received

Under the new approach, grants received towards the cost of an asset are recognised in income unless the funder imposes a condition on the grant e.g. that it must be used to fund the construction or acquisition of an asset. If there are no conditions, or once all conditions have been met, the grant is recognised in full in within income. If adopted, the impact is likely to be an increase in volatility in annual results where capital grants are received or released once conditions have been met. When the change is applied, the existing government grants deferred account is likely to be realised to Income and Expenditure Reserve.

ii) Donated assets

The new approach for donated assets is effectively identical to that for grants above. Where donations are received without conditions, or if they have conditions, once these have been met, they should be recognised in income. If brought into effect it would result in most, or all, donations being reflected in income in the year of receipt which could lead to greater volatility in the annual result. The existing donated asset reserve would be transferred to the income and expenditure reserve and, where it includes an element of asset revaluations, to the revaluation reserve.

c) Other changes
The HM Treasury dispensation from applying IAS 27 to NHS charitable funds only applies to 2010/11. If this dispensation is not extended then, in 2011/12, 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 Trusts 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.

2.0 Operating Income by classification

	2010/11 £000	2009/10 £000
Income from Activities		
Cost and Volume Contract income	137,336	143,135
Block Contract income	71,023	60,881
Total income from activities	**208,359**	**204,016**
Other operating income		
Research and development		
Education and training	9,742	9,686
Charitable and other contributions to expenditure	–	7
Transfer from donated asset reserve in respect of depreciation on donated assets	70	62
Non-patient care services to other bodies	2,675	3,098
Other *	5,073	5,770
Profit on disposal of land and buildings	–	57
Total other operating income	**17,560**	**18,680**
Total operating income	**225,919**	**222,696**

*Other income includes £nil relating to Care Services Improvement Partnership (2009-10 £1.4m), £0.9m relating to income from Rapid Assessment Interface Discharge (RAID) services (2009-10 £0.3m) and £0.7m relating to Yardley Green (2009-10 £0.4m).

2.1 Income from activities from mandatory services

	2010/11 £000	2009/10 £000
Income from activities arising from mandatory services	205,235	203,047
Income from activities arising from non-mandatory services	20,684	19,649
	225,919	**222,696**

2.2 Private patient income

	2010/11 £000	2009/10 £000	Base Year £000
Private patient income	–	–	–
Total patient related income	208,359	204,016	204,016
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% 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 and Secure and Complex Care and Mental Health Services for Older People. 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 of the Trusts 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.

	2010/11			
	Healthcare Income	Corporate	Other reconciling Items	Total
	£000	£000	£000	£000
Income	206,068	3,041	(750)	208,359
Depreciation	(2,645)	(1,640)	–	(4,285)
Interest Revenue	–	156	–	156
Interest Expense	(4,131)	–	–	(4,131)
Surplus / (deficit)	22,047	(21,116)	(2,686)	(1,755)

	2009/10			
	Healthcare Income	Corporate	Other reconciling Items	Total
	£000	£000	£000	£000
Income	201,710	2,306	–	204,016
Depreciation	(3,169)	(1,100)	–	(4,269)
Interest Revenue	–	112	–	112
Interest Expense	(3,557)	16	–	(3,541)
Surplus / (deficit)	25,976	(23,031)	(13,206)	(10,261)

The reconciling items relate to impairment of property, plant and equipment and final adjustments made to the final year end financial statements which are not allocated in segmental information reviewed by the Board.

4 Operating expenses	2010/11 £000	2009/10 £000
Services from NHS Foundation Trusts	2,015	2,595
Services from NHS Trusts	775	312
Services from other NHS Bodies	3,263	2,684
Employee Expenses - Executive directors	817	760
Employee Expenses - Non-executive directors	130	126
Employee Expenses - Staff	167,204	163,796
Drug costs	7,376	7,349
Supplies and services - clinical (excluding drug costs)	359	564
Supplies and services - general	4,278	4,472
Establishment	4,398	4,505
Research and development	–	–
Transport	1,147	1,281
Premises	12,787	15,034
Increase / (decrease) in bad debt provision	343	517
Depreciation on property, plant and equipment	4,284	4,270
Audit fees (note 4.2)		
Audit services - statutory audit	79	65
Other auditors remuneration		
Other services	1	10
Clinical negligence	408	407
Other	6,509	4,080
TOTAL	**216,173**	**212,827**

4.1 Exceptional items	2010/11 £000	2009/10 £000
Impairments of property, plant and equipment	5,334	13,206
Reversal of impairments of property, plant and equipment	(2,644)	–
Termination benefits	2,599	712
TOTAL	**5,289**	**13,918**

4.2 Analysis of profit / (loss) on disposal	2010/11 Total £000	2009/10 Total £000
Disposal of protected assets	–	–
Disposal of non-protected assets	–	57
TOTAL	**–**	**57**

4.3 Auditor Remuneration

The Board of Governors appointed PricewaterhouseCoopers LLP (PwC) as external auditors of the Trust for the three years commencing 2010/11. The audit fee for the statutory audit was £55,000 excluding VAT. This was the fee for an audit in accordance with the Audit Code issued by Monitor in October 2007. The liability of PwC for all claims connected with services provided (including but not limited to negligence) is limited to £1,000,000.

The previous auditors were the Audit Commission and the fee for the 2009/10 audit was £55,000 excluding VAT. In addition to this, the Audit Commission was paid £9,000 excluding VAT for other non-audit work. The liability of the Audit Commission for all claims connected with services provided (including but not limited to negligence) was ten times the fee payable.

The current year disclosure includes £21,708 paid to Audit Commission for audit services relating to 2009-10 which was not accrued in the previous financial year.

4.4 Arrangements containing an operating lease	2010/11 £000	2009/10 £000
Minimum lease payments	1,945	2,017
Contingent rents	–	–
TOTAL	**1,945**	**2,017**

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 £1.4m which is included within operating costs. The leases for vehicles and equipment range from 1 to 5 years and have an annual charge of £0.3m which is included within operating costs.

The Trusts most significant lease arrangement is for the lease of Trust Headquarters. This is a 25 year lease expiring in 2030 and has an annual rental charge of £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	2010/11 £000	2009/10 £000
Not later than one year	1,526	1,392
Later than one year and not later than five years	4,183	4,436
later than five years	11,143	10,609
TOTAL	**16,852**	**16,437**

5 Directors' remuneration	2010/11 Total £000	2009/10 Total £000
Directors' remuneration	765	715
Social security costs	88	83
Employer contributions to a pension scheme in respect of directors'	94	88
TOTAL	**947**	**886**

The medical director was paid £63k (2009-10 £59k), which is not included in the above disclosure, for his non-director responsibilities.

5.1 "Directors' advances	2010/11 Total £000	2009/10 Total £000
Amounts due from / (to) directors:	9	15
	9	**15**

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)	2010/11 Total £000	2009/10 Total £000
Salaries and wages	135,179	132,564
Social security costs	10,269	9,969
Employers contributions to NHS pensions	15,325	14,753
Termination benefits (see note 4.5)	2,599	712
Agency/contract staff	7,363	7,417
	170,735	165,415
Less capitalised cost	(115)	(147)
TOTAL RECOGNISED IN OPERATING EXPENSES	**170,620**	**165,268**

6.1 Average number of employees (WTE basis)

	2010/11 Number	2009/10 Number
Medical	253	264
Administration and estates	573	546
Healthcare assistants and other support staff	794	782
Nursing and health visiting staff	1,299	1,311
Scientific, therapeutic and technical staff	469	424
Bank and agency staff	252	235
Other	155	157
TOTAL	**3,795**	**3,719**

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.

	2010/11 £000	2010/11 Number	2009/10 £000	2009/10 Number
No of early retirements on the grounds of ill-health		7		6
Value of early retirements on the grounds of ill-health	785		467	

6.3 Staff exit packages

Exit package cost band	Number of compulsory redundancies 2010/11	Number of other agreed departures 2010/11	Total number of exit packages by cost band 2010/11	Total number of exit poackages by cost band 2009/10
<£10,000	6	-	6	-
£10,000 - £25,000	5	-	5	1
£25,001 - £50,000	4	1	5	2
£50,001-£100,000	1	-	1	-
£100,001 - £150,000	-	-	-	-
£150,001 - £200,000	-	-	-	-
Total number of exit packages by type	16	1	17	3
Total resource cost £'000	310	42	352	105

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

	2010/11 £000	2009/10 £000
Interest on loans and receivables	156	112
TOTAL	**156**	**112**

8 Finance costs

	2010/11 £000	2009/10 £000
Loans from the Foundation Trust Financing Facility	528	68
Finance Costs in PFI obligations		
Main Finance Costs	3,162	3,214
Contingent Finance Costs	441	259
TOTAL	**4,131**	**3,541**

9 Intangible assets	Total	Softeware licences (purchased)	Licences and trademarks (purchased)
	£000	£000	£000
Cost or valuation at 1 April 2009, 1 April 2010, 31 March 2010 and 31 March 2011	**274**	–	253
Amortisation at 1 April 2009, 1 April 2010, 31 March 2010 and 31 March 2011	**274**	**–**	253
Net book value			
NBV - Purchased at 1 April 2010 and 31 March 2011	–	–	–
NBV - Donated at 1 April 2010 and 31 March 2011	–	–	–
NBV total at 1 April 2010 and 31 March 2011	–	–	–

10 Property, plant and equipment 31 March 2011	Total	Land	Buildings excluding dwellings
	£000	£000	£000
Cost or valuation at 1 April 2010	**208,413**	51,114	139,832
Additions - purchased	19,555	–	2,732
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 31 March 2011	**185,380**	**48,287**	**118,962**
Accumulated depreciation at 1 April 2010	**43,244**	**–**	37,337
Provided during the year	4,284	–	3,109
Impairments recognised in operating expenses	5,334	1,465	3,869
Reversal of impairments	(2,644)	–	(2,615)
Reclassifications	–	–	–
Revaluation surpluses	–	–	–
Transferred to cost or valuation*	(43,179)	(1,465)	(41,700)
Disposals	(27)	–	–
Accumulated depreciation at 31 March 2011	**7,012**	**–**	**–**
Net book value			
NBV - Purchased at 1 April 2010	**163,285**	49,964	101,828
NBV - Donated at 1 April 2010	**1,884**	1,150	667
NBV total at 1 April 2010	**165,169**	**51,114**	**102,495**
Net book value			
NBV - Purchased at 31 March 2011	**176,372**	47,137	118,170
NBV - Donated at 31 March 2011	**1,996**	1,150	792
NBV total at 31 March 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 accordance with IAS 16 - Property, Plant and Equipment. The values reported also include an element relating to the previous financial year.

The net book value of assets held under finance lease arrangements is £46,347k (2009/10 £44,744k). Depreciation of £834k (2009/10 £1,071k) was charged on these assets in the year.

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 & POA £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000
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
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**

10.1 Analysis of property, plant and equipment 31 Mar 2011	Total	Land	Buildings excluding dwellings
	£000	£000	£000
Net book value			
NBV - Protected assets at 31 March 2011	**139,599**	31,330	108,269
NBV - Unprotected assets at 31 March 2011	**38,769**	16,957	10,693
Total at 31 March 2011	**178,368**	**48,287**	**118,962**

Property, plant and equipment is classified as protected if it is required for the purposes of providing either mandatory goods and services or man

10.2 Property, plant and equipment 31 March 2010	Total	Land	Buildings excluding dwellings
	£000	£000	£000
Cost or valuation at 1 April 2009	**205,117**	51,244	143,876
Additions - purchased	**10,651**	**–**	1,521
Impairments charged to revaluation reserve	**(6,520)**	–	(6,477)
Reclassifications	–	–	1,102
Revaluation surpluses	–	–	–
Disposals	**(835)**	**(130)**	**(190)**
Cost or valuation at 31 March 2010	**208,413**	**51,114**	**139,832**
Accumulated depreciation at 1 April 2009	**26,145**	–	20,538
Provided during the year	**4,270**	**–**	3,455
Impairments recognised in operating expenses	**13,352**	13,352	–
Reversal of impairments	–	–	–
Reclassifications	–	–	–
Revaluation surpluses	–	–	–
Disposals	**(523)**	**–**	(8)
Accumulated depreciation at 31 March 2010	**43,244**	**–**	**37,337**
Net book value			
NBV - Purchased at 1 April 2009	**176,880**	50,094	122,476
NBV - Donated at 1 April 2009	**2,092**	1,150	862
NBV total at 1 April 2009	**178,972**	**51,244**	**123,338**
Net book value			
NBV - Purchased at 31 March 2010	**163,285**	49,964	101,828
NBV - Donated at 31 March 2010	**1,884**	1,150	667
NBV total at 31 March 2010	**165,169**	**51,114**	**102,495**

The net book value of assets held under finance lease arrangements is £44,744k (2008/9 £51,129k). Depreciation of £1,071k (2008/9 £1,555k) w

10.3 Analysis of property, plant and equipment 31 Mar 2010	Total	Land	Buildings excluding dwellings
	£000	£000	£000
Net book value			
NBV - Protected assets at 31 March 2010	**125,189**	32,971	92,218
NBV - Unprotected assets at 31 March 2010	**39,980**	18,143	10,277
Total at 31 March 2010	**165,169**	**51,114**	**102,495**

Dwellings £000	Assets under Construction & POA £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000
–	–	–	–	–	–
375	5,192	1,415	–	2,921	1,216
375	**5,192**	**1,415**	–	**2,921**	**1,216**

datory education and training.

Dwellings £000	Assets under Construction & POA £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000
432	1,042	1,905	93	3,019	3,506
–	7,610	671	–	717	132
(43)	–	–	–	–	–
	(1,102)	–	–	–	–
–	–	–	–	–	–
–	**–**	**(27)**	**–**	**(488)**	**–**
389	**7,550**	**2,549**	**93**	**3,248**	**3,638**
–	–	1,739	92	1,862	1,914
23	–	70	1	405	316
–	–	–	–	–	–
–	–	–	–	–	–
–	–	–	–	–	–
–	–	–	–	–	–
–	–	(27)	–	(488)	–
23		**1,782**	**93**	**1,779**	**2,230**
432	1,042	86	1	1,157	1,592
–	–	80	–	–	–
432	**1,042**	**166**	**1**	**1,157**	**1,592**
366	7,550	700	–	1,469	1,408
–	–	67	–	–	–
366	**7,550**	**767**	**–**	**1,469**	**1,408**

as charged on these assets in the year.

Dwellings £000	Assets under Construction & POA £000	Plant & Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000
-	-	-	-	-	-
366	7,550	767	-	1,469	1,408
366	**7,550**	**767**	**-**	**1,469**	**1,408**

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 & POA		
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	5	8
Furniture & 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 2011 with an effective valuation date of 31 March 2011. Fair values were determined based on estimates. The impairment gains and loss recognised in the financial statements arose due to movement in market prices.

11 Inventories	31 Mar 2011 £000	31 Mar 2010 £000
Drugs	268	414
Materials	37	46
TOTAL inventories	**305**	**460**

11.1 Inventories recognised in expenses	31 Mar 2011 £000	31 Mar 2010 £000
Inventories recognised in expenses	4,688	4,768
Write-down of inventories recognised as an expense	–	60
Reversal of any write down of inventories resulting in a reduction of recognised expenses	(17)	(25)
TOTAL inventories recognised in expenses	**4,671**	**4,803**

12 Trade receivables and other receivables

	Total	Financial assets	Non-financial assets	Total	Financial assets	Non-financial assets
	31 March 2011 £000	31 March 2011 £000	31 March 2011 £000	31 March 2010 £000	31 March 2010 £000	31 March 2010 £000
Current						
NHS Receivables	**3,430**	3,430	–	**3,084**	3,084	–
Other receivables with related parties	**5**	5	–	**5**	5	–
Provision for impaired receivables	**(1,395)**	(1,395)	–	**(1,068)**	(1,068)	–
Prepayments	**1,872**	–	1,872	**676**	–	676
PFI Prepayments						
Prepayments - Capital contributions	–	–	–	–	–	–
Prepayments - Lifecycle replacements	–	–	–	–	–	–
PDC receivable	**137**		137	–	–	–
Other receivables	2,599	1,963	636	1,998	1,699	299
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**6,648**	**4,003**	**2,645**	**4,695**	**3,720**	**975**
Non-Current						
NHS Receivables	–	–	–	–	–	–
Other receivables with related parties	**4**	4	–	**10**	10	–
Provision for impaired receivables	–	–	–	–	–	–
Prepayments	–	–	–	–	–	–
PFI Prepayments						
Prepayments - Capital contributions	–	–		–		–
Prepayments - Lifecycle replacements	**1,521**	–	1,521	**1,162**	–	1,162
Other receivables	–	–	–	–	–	–
TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES	**1,525**	**4**	**1,521**	**1,172**	**10**	**1,162**

12.1 Trade receivables and other 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.

	31 March 2011 £000	31 March 2010 £000
At 1 April	1,068	568
Increase in provision	343	517
Amounts utilised	(16)	(17)
Unused amounts reversed	–	–
At 31 March	**1,395**	**1,068**

12.2 Analysis of impaired receivables

	31 March 2011 £000	31 March 2009 £000
Ageing of impaired receivables		
Up to three months	589	961
In three to six months	382	107
Over six months	1,072	–
TOTAL	**2,043**	**1,068**
Ageing of non-impaired receivables past their due date		
Up to three months	1,795	4,053
In three to six months	325	358
Over six months	88	209
TOTAL	**2,208**	**4,620**

13 Trade and other payables	Total 31 March 2011 £000	Financial liabilities 31 March 2011 £000	Non-financial liabilities 31 March 2011 £000	Total 31 March 2010 £000	Financial liabilities 31 March 2010 £000	Non-financial liabilities 31 March 2010 £000
Current						
NHS payables	**4,023**	4,023	–	**3,018**	3,018	–
Trade payables - capital	**1,360**	1,360	–	**167**	167	–
Other trade payables	–	–	–	–	–	–
Taxes payable	**3,451**	–	3,451	**3,336**	–	3,336
Other payables	**8,826**	8,826	–	**7,234**	7,234	–
Accruals	**5,588**	5,588	–	**4,748**	4,748	–
PDC payable	–	–	–	**152**	–	152
TOTAL CURRENT TRADE AND OTHER PAYABLES	**23,248**	**19,797**	**3,451**	**18,655**	**15,167**	**3,488**
Non-current						
NHS payables	–	–	–	–	–	–
Trade payables - capital	–	–	–	–	–	–
Taxes payable	–	–	–	–	–	–
Other payables	–	–	–	–	–	–
Accruals	–	–	–	–	–	–
TOTAL NON CURRENT TRADE AND OTHER PAYABLES	–	–	–	–	–	–

Other payables above includes £1,269k (2009/10 £1,246k) in respect of outstanding employer Pension contributions.

14 Other liabilities	31 March 2011 £000	31 March 2010 £000
Current		
Deferred Income	9,259	10,475
Deferred Government Grant	145	150
TOTAL OTHER CURRENT LIABILITIES	**9,404**	**10,625**
Non-current		
Deferred Income	–	–
Deferred Government Grant	–	–
TOTAL OTHER NON CURRENT LIABILITIES	–	–

15 Borrowings	31 March 2011 £000	31 March 2010 £000
Current		
Obligations under Private Finance Initiative contracts	1,720	2,060
TOTAL CURRENT BORROWINGS	**1,720**	**2,060**
Non-current		
Loans from Foundation Trust Financing Facility	19,169	5,314
Obligations under Private Finance Initiative contracts	64,478	66,198
TOTAL OTHER NON CURRENT LIABILITIES	**83,647**	**71,512**

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 31 March 2010). The Trust had drawn down £nil of its working capital facility at 31 March 2011 (£nil 31 March 2010).

The Trust has a prudential borrowing limit (PBL) of £135.0m in 2010/11 (£143.3m 2009/10). The Trust has actually borrowed £85.4m as at 31 March 2011 (£73.6m at 31 March 2010).

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 £135.0m. This two tier system is needed as when PFI liabilities are recognised "on balance sheet" on transition to International Financial Reporting Standards, the tier one ratios are no longer appropriate to sufficiently monitor the Trusts financial performance against the tier one borrowing limit.

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

	Threshold	31 March 2011	31 March 2010
Minimum dividend cover	>1x	4.5	3.9
Minimum interest cover	>2x	3.4	4.0
Minimum debt service cover	>1.5x	2.3	2.6
Maximum debt service to revenue	<10%	2.7%	2.5%

The limit of £135.0m 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)

	Thursday, 31 March 2011 £000	Wednesday, 31 March 2010 £000
Gross PFI liabilities		
of which liabilities are due		
- not later than one year;	4,800	5,222
- later than one year and not later than five years;	18,011	18,500
- later than five years.	102,169	106,480
Finance charges allocated to future periods	(58,782)	(61,944)
Net PFI liabilities	**66,198**	**68,258**
- not later than one year;	1,720	2,060
- later than one year and not later than five years;	6,393	6,599
- later than five years.	58,085	59,599
TOTAL	**66,198**	**68,258**

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:

	31 Mar 2011 Total £000	31 Mar 2011 PFI 1 £000	31 Mar 2011 PFI 2 £000	31 Mar 2010 Total £000
26th to 30th years (inclusive)	**2,876**	2,876	–	2,743
36th year and beyond	**6,025**	–	6,025	5,691

17.2 PFI commitments (on SoFP)

	Thursday, 31 Mar 2011 £000	Wednesday, 31 Mar 2010 £000
Commitments in respect of the service element of the PFI		
- not later than one year;	8,901	8,708
- later than one year and not later than five years;	37,988	37,039
- later than five years.	394,171	404,023
	41,060	**449,770**
Present value of commitments		
- not later than one year;	8,463	8,279
- later than one year and not later than five years;	31,885	31,085
- later than five years.	163,380	163,589
TOTAL	**203,728**	**202,953**

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-balance sheet by the Trust following a review of the contracts based on Treasury Task force Technical Note 1 “How to account for PFI transactions” which interprets IAS16 ‘’Property, Plant and Equipment’’ and IFRIC12’’ Service Concession Arrangements’’. The annual Unitary Charge is linked to annual movement is 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 5 years.

The contract stipulates obligations on the Trust and Healthcare Support (Erdington) Limited. Should either party default on its contractual obligations then the other party has the right to terminate the contract. Provisions for compensation are included within the contract which include the Trust settling the amount of outstanding senior debt.

PFI 2 - Birmingham New Hospital Projects
This is a 38 year contract with Consort Healthcare (Birmingham) Limited which commenced in July 2008 and is for the provision of three buildings including “hard” facility management services. The PFI contract was jointly undertaken by the Trust and University Hospital Birmingham NHS Foundation Trust (UHB) for the “Birmingham Super Hospitals” in Selly Oak of which the Trust provides Mental Health services. Only the assets, liability, income and expenditure directly attributable to the Trust under the contract are disclosed in these accounts. The service provision is implicitly for the patients, staff and visitors of the Trust. This contract has been treated as being on-balance sheet by the Trust following a review of the contracts based on Treasury Task force Technical Note 1 “How to account for PFI transactions” which interprets IAS16 ‘’Property, Plant and Equipment’’ and IFRIC12’’ Service Concession Arrangements’’. The annual Unitary Charge is linked to annual movement is RPI. On the 15th anniversary of the commencement of the contract the Unitary Payment is subject to a market testing exercise.

At the end of the concession period, the ownership of the three buildings transfers to the Trust at which point the contract will expire.

The contract contains various termination clauses including voluntary, events of default, Force Majeure, and termination due to material non-availability clauses each having its own compensation mechanism. The voluntary termination clause requires the Trust to act jointly with UHB.

18 Provisions for liabilities and charges

	Total	Legal claims	Property	Restructuring	Injury Allowance	Other
	£000	£000	£000	£000	£000	£000
At 1 April 2010	**1,813**	**234**	**713**	**607**	**259**	**–**
Arising during the year	**3,611**	195	391	2,599	44	382
Utilised during the year	**(378)**	(62)	(67)	(184)	(65)	–
Reversed unused	**(329)**	(78)	(251)	–	–	–
Unwinding of discount	–	–	–	–	–	–
At 31 March 2011	**4,717**	**289**	**1,037**	**2,771**	**238**	**382**
Expected timing of cashflows:						
- not later than one year;	**3,696**	289	203	2,771	51	382
- later than one year and not later than five years;	**363**	–	258	–	105	–
- later than five years.	**658**	–	576	–	82	–
TOTAL	**4,717**	**289**	**1,037**	**2,771**	**238**	**382**

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 2011/12.The Trust has £80k (2009/10 £nil) 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 2011/12.

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 2011-12.

18.1 Clinical Negligence liabilities

	31 Mar 2011 £000	31 Mar 2010 £000
Amount included in provisions of the NHSLA in respect of clinical negligence liabilities of Birmingham and Solihull Mental Health NHS Foundation Trust	1,045	934

19 Contractual Capital Commitments

The Trust was contractually committed to £26,684k (£11,785k at 31 March 2010) of capital expenditure for the purchase of property, plant and equipment.

20 Third Party Assets

The Trust held £812k cash and cash equivalents at 31 March 2011 (£785k 31 March 2010) 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.

21 Cash and cash equivalents

	Thursday, 31 March 2011 £000	31 March 2010 £000
At 1 April	32,097	19,862
Net change in year	1,516	12,235
At 31 March	**33,613**	**32,097**
Broken down into:		
Cash at commercial banks and in hand	43	38
Cash at OPG (Office of Paymaster General)	33,570	32,059
Cash and cash equivalents as in SoFP	**33,613**	**32,097**
Bank overdraft	–	–
Cash and cash equivalents as in SoCF	**33,613**	**32,097**

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:

	Income >£1.5m 2010/11 £000	2009/10 £000
University Hospital Birmingham NHS Foundation Trust	1,944	1,572
London Strategic Health Authority	6,649	7,360
West Midlands Strategic Health Authority	6,831	7,294
Birmingham East & North PCT	161,332	71,292
Heart of Birmingham Teaching PCT	16,532	53,978
Sandwell PCT	1,672	1,837
Solihull Care Trust	16,090	16,344
South Birmingham PCT	4,520	52,788

	Expenditure >£1.5m 2010/11 £000	2009/10 £000
South Birmingham PCT	2,974	1,473
Heart of England NHS Foundation Trust	2,263	2,376
Prescription Pricing Authority	2,628	3,750

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 Thursday, 31 Mar 2011 £000	31 Mar 2010 £000
University Hospital Birmingham NHS Foundation Trust	1,072	736
Birmingham East & North PCT	1,117	418
Birmingham City Council	1,020	1,084

	Payables > £0.5m Thursday, 31 Mar 2011 £000	31 Mar 2010 £000
Heart of England NHS Foundation Trust	1,345	1,100
NHS Business Services Authority	741	620

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 £19k (2010 £9k) from the Charity for expenses incurred by the Trust related to the Charity.

In addition to these balances the Trust was owed £9k (2010 £15k) 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

	2010/11 £000	2009/10 £000
Salaries and other short term benefits	853	798
Pension contributions	94	88
Total	**947**	**886**

Key management personnel are considered to be the Executive and Non-Executive Directors of the Trust.

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 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2011 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

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

	Thursday, 31 March 2011		31 March 2010	
	Total	Loans and receivables	Total	Loans and receivables
	£000	£000	£000	£000
Assets as per SoFP				
Trade and other receivables excluding non financial assets	**4,007**	4,007	**3,730**	3,730
Cash and cash equivalents (at bank and in hand	**33,613**	33,613	**32,097**	32,097
TOTAL AT 31 MARCH	**37,620**	**37,620**	**35,827**	**35,827**

25 Financial liabilities by category

	Thursday, 31 March 2011		31 March 2010	
	Total	Other financial liabilities	Total	Other financial liabilities
	£000	£000	£000	£000
Liabilities as per SoFP				
Borrowings excluding Finance lease and PFI liabilities	**19,169**	19,169	**5,314**	5,314
Obligations under Private Finance Initiative contracts	**66,198**	66,198	**68,258**	68,258
Trade and other payables excluding non financial assets	**19,797**	19,797	**15,167**	15,167
TOTAL AT 31 MARCH	**105,164**	**105,164**	**88,739**	**88,739**

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 118 cases of losses and special payments totalling £103k during the year to 31 March 2011 (148 cases totalling £231k during year to 31 March 2010). These amounts are reported on an accruals basis but excluding provisions for future losses.

27 Pensions

Pension costs

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.pensions.nhsbsa.nhs.uk. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General 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.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

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 to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

27 Pensions (continued)

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 by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website.

“c) Scheme provisions
The scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member’s pension is normally payable to the surviving spouse.

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, less pension already paid, subject to a maximum amount equal to twice the member’s final year’s pensionable pay less their retirement lump sum for those who die 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 statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

The scheme provides the opportunity to members to increase their benefits through money purchase additional voluntary contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee’s pension benefits. The benefits payable relate directly to the value of the investments made.

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