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Birmingham and Solihull Mental Health
NHS Foundation Trust

Annual report and accounts 2017/18

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Mental Health NHS Foundation Trust

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Performance report

Overview

The purpose of this overview is to give readers of this report a short summary that provides them with sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

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 1 April 2017 to 31 March 2018.

As you will read in this report, this has been a year when partnerships have been at the forefront of new services and developments and a part of everything we do as a Trust. Our Reach Out accountable care partnership with South Staffordshire and Shropshire Healthcare NHS Foundation Trust and St Andrew's Healthcare has performed strongly in its first year, with a reduction in service users in inpatient units coupled with a significant increase in the numbers being supported in the community, in line with the principle of caring for people in the least restrictive setting. The MERIT vanguard has also seen some significant achievements during the past two years. Notable amongst these are the development of an electronic shared health record viewer and co-ordinated bed management function and bed viewer across the four mental health trusts in the West Midlands conurbation, as well as introduction of a training passport that allows staff to move between the trusts more easily. These and other shared activity and developments led to a firm commitment from all four trusts, now joined by Forward Thinking Birmingham, to continue this work after the NHS England vanguard funding came to an end in March 2018. The RAIDPlus Test Bed has also made significant strides in developing systems and technologies to prevent mental health crises, and has secured additional funding to build on this work.

Our commitment to strategic partnerships was underlined by the recruitment of a new Executive Director of Strategic Partnerships, who joined the Trust in August 2017. This addition to the Board has had a significant impact on the Trust's approach to working with partners in all sectors, sometimes in ways we had not previously considered. This has not only included contributing to the refresh of the Birmingham and Solihull Sustainability and Transformation Partnership (STP), but has also been the catalyst for exciting new partnerships and collaborations. We have seen the development of a memorandum of understanding with Birmingham Women's and Children's NHS Foundation Trust to improve mental healthcare for young people, and strengthening of our relationships with GP federations and super-partnerships, local authorities and the charitable, voluntary and commercial sectors. This work is part of an ambitious vision for mental health for 2030 that will rely on key partnerships to succeed.

Working in collaboration with other organisations and service users is a theme that you will also see running throughout the new developments and achievements highlighted in this report. From the ground breaking rehabilitation service at Rookery Gardens and our perinatal community services, through to our approach to Prevent, recovery and learning from deaths, partnership working is critical to everything we do and is essential to making sustainable improvements in today's health and social care system.

We remain committed to ensuring that our local and regional populations have the best quality mental healthcare and during the year, we have been successful in bids to keep existing services and provide new services. These include continuing to provide the Recovery Near You drug and alcohol service in Wolverhampton in partnership with Nacro and Aquarius and winning tenders to provide a specialist forensic community service for young people across the West Midlands and a service for veterans with complex mental health problems. We also secured funding from commissioners to open new beds to help achieve the ambition of eliminating out of area placements.

Our teams have continued to be recognised outside of the Trust, with a strong representation in the Thrive Mental Health Commission awards and the Solihull Together awards, where the Trust was a winner in five out of nine categories. The Trust was also named Innovative Organisation of the Year and won the Mental Health Innovation award at the West Midlands Academic Health Science Network's Celebration of Innovation awards.

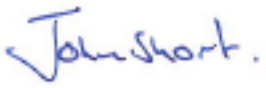
We have had many successes and achieved much in 2017/18, however as a Trust with openness and honesty at its heart, we not only celebrate these achievements but also recognise where a focus on improvement is needed. We started the year having just had a full inspection from the Care Quality Commission (CQC). When its report was published in August 2017, we were pleased that the majority of our services were rated 'good', our staff were found to be caring, compassionate and kind, and the feedback from our external partners and stakeholders was positive about the Trust's role in addressing the challenges faced by the health economy. However, we were very disappointed to be given an overall rating of 'requires improvement'. Whilst we raised concerns with the CQC over how some judgements were made, we accepted that improvements were needed across a number of areas. A detailed action plan to address the CQC's concerns was put in place and much of that plan has been achieved during the year. We were delighted that some of this hard work was rewarded when our Solar service for children and young people in Solihull improved its rating from 'inadequate' to 'good' within the space of nine months.

Following the inspection, we have also reflected on the wider work we need to do to build on our current quality initiatives and the improvements we have demonstrated against our ambitious quality goals. We are about to embark on the development and implementation of a Trustwide quality improvement programme to ensure that our staff and teams at every level are empowered and enabled to identify and make improvements, using a consistent and proven approach. As well as improving the quality of care for our service users and their carers, this aims to improve the experience and involvement of our staff, who told us through the annual staff survey that we have improved in some areas such as health and wellbeing, but are not doing enough to address some of the issues that concern them.

Despite the CQC rating, the innovative work of our Trust and commitment and compassion of our staff continues to impress at a national level. Following a visit in December 2017, Secretary of State for Health Jeremy Hunt commended the Trust's thoughtful and thorough approach to safety and continuous improvement. Once again our collaborative approach was highlighted during this visit, with the Secretary of State particularly commenting on how pleased he was to find representatives of other services involved in the question and answer session, demonstrating a real commitment to integrated services. In March 2018, Lord O'Shaughnessy, Under Secretary of State at the Department of Health, visited the Trust to find out more about our work as a Global Digital Exemplar. He commented on the hugely positive impact this work is having on both staff and service users and thanked us for the Trust's leadership in this area.

The Trust has a strong financial track record with significant cost savings achieved over the last five years. Going forward, we will strike an appropriate balance between quality, service delivery and financial sustainability and acknowledge the scale of this task. Our planned quality improvement programme will be a key driver of future sustainability, fully involving and engaging staff from across the Trust.

We would like to thank all our staff for their continued compassion and commitment to continuously seeking new and innovative ways to improve the wellbeing and experience of the people we care for. This also extends to the partners who have worked with us so closely, including our service users and their carers, and who this report so clearly demonstrates are critical to us achieving our vision for mental health.



John Short
Chief Executive

Sue Davis, CBE
Chair

Purpose and activities of our Trust

Our purpose is simple and straightforward:

To provide excellent, compassionate, high quality mental health services that are innovative and involve service users, carers and staff.

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

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

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

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

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

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

We provide a comprehensive mental healthcare service for residents of Birmingham and Solihull, and to communities in the West Midlands and beyond. We operate out of more than 40 sites and serve a culturally and socially diverse population of 1.3 million spread over 172 square miles, have an annual income of £235 million and a dedicated workforce of almost 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.

During the year we provided care to more than 64,000 service users, 2,500 of whom were cared for in our inpatient services and 1,600 who were supported by the Solihull Integrated Addictions Services. More than 18,500 of our service users received help from our Birmingham Healthy Minds service which provides access to psychological therapies for people aged over 16 with anxiety, stress, low mood and depression.

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

Our services

We provide a wide range of inpatient, community and specialist mental health services for service users from the age of 16 upwards in Birmingham and for all ages in Solihull. These services are located within our four service areas: Acute and Urgent Care, Integrated Community Care and Recovery, Specialties, and Secure Care and Offender Health. Together, these services include elements of rehabilitation, crisis and home treatment, assertive outreach, early intervention, addictions, day services and mental health wellbeing. We provide our services on a local, regional and national basis. In addition, our Trust manages the delivery of all healthcare services at HM Prison Birmingham, in Winson Green, and works closely with the criminal justice system.

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

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

Our strategic ambitions

Our three year strategy for 2017-2020 includes six strategic ambitions that drive our work:

- We will put service users first and provide the right care, closer to home, whenever it's needed.
- We will listen to and work alongside service users, carers, staff and stakeholders.
- We will champion mental health wellbeing and support people in their recovery.
- We will attract, develop and support an exceptional and valued workforce.
- We will drive research, innovation and technology to enhance care.
- We will work in partnership with others to achieve the best outcomes for local people.

History and statutory background

Our Trust was established as Birmingham and Solihull Mental Health NHS Foundation Trust on 1 July 2008. This followed the merger of the former Northern and South Birmingham Mental Health NHS Trusts on 1 April 2003 to create Birmingham and Solihull Mental Health Trust.

Key issues and risks that could affect the Trust

The Trust has identified a number of key risks which are included in its Board Assurance Framework. The high level risks largely represent:

- financial risks associated with missed savings targets for secure care and renewal of Microsoft licences
- insufficient capacity to manage admissions across the acute care and assertive outreach pathways
- insufficient staff resulting in the use of agency staff
- risk of aggression to staff from older adult service users
- increasing threats of violence to staff based in HMP Birmingham
- risk to staff of prisoners using legal highs within HMP Birmingham
- difficulties in issuing and administering prescriptions via the EPMA system
- the monitoring of waiting time levels and the impact of waiting lists for care-co-ordinators.

Further information on risks and associated controls is available in the Annual Governance Statement section of this annual report.

Financial environment

Looking forward to 2018/19, the challenging financial times will continue. Our healthcare income is increasing by 0.1 per cent, the rise in inflation of costs will continue and we will need to deliver savings of 3.9 per cent, made up of efficiency targets, undelivered savings from 2017/18 and investment in our services. Delivery of savings while maintaining quality of service continues to be a risk to our Trust that continues to be monitored through our internal Savings Board, and Programme Management Board.

Going concern disclosure

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

Performance analysis

Development and performance of the Trust during 2017/18

Performance against key targets

We continue to meet and exceed the mental health national access waiting time standards that are in place for the following three service areas:

- First episode psychosis services - 50 per cent of service users experiencing a first episode of psychosis are seen by their early intervention services and commence NICE compliant treatment within two weeks of referral. As at the end of March 2018, we achieved 100 per cent.

- Increasing access to psychological therapies services (IAPT) - 75 per cent of people referred to the IAPT service beginning treatment within six weeks of referral and 95 per cent beginning treatment within 18 weeks of referral. As at the end of March 2018, we exceeded both targets with 95 per cent of service users beginning treatment within six week and 100 per cent within 18 weeks.

- Children and young people's eating disorders services - children and young people (up to the age of 19) referred for assessment or treatment for an eating disorder should receive NICE approved treatment with a designated healthcare professional within one week for urgent cases and four weeks for every other case. As at the end of March 2018, 100 per cent of urgent cases were seen within one week and 100 per cent of routine cases were seen within four weeks.

New developments and achievements

Opening of Rookery Gardens – July 2017 saw the opening of Rookery Gardens on our Ardenleigh site. This groundbreaking approach to rehabilitation and recovery for service users with complex mental health issues provides a number of houses for service users who are supported by a single team that draws together expertise from the Trust and Birmingham Mind in an integrated recovery service. Recovery navigators from Birmingham Mind support service users in gaining and maintaining their independence, social networking, housing, employment and education as part of their rehabilitation programme.

Perinatal community services – one of NHS England's priorities in the Five Year Forward View for Mental Health is to enable more women each year to access appropriate specialist perinatal mental health community services to support themselves, their babies and families. In 2017 we were successful in our bid to receive funding to be a Wave 1 pilot site delivering a service to women who give birth at Birmingham Women's Hospital. Our service celebrated its successes from its first year of operation in April 2018. These included 253 women seen, shorter waiting times for assessment, choice over where to be seen, NICE concordant psychological interventions and parent-infant interventions. We bid for further funding under Wave 2 of the programme to expand this service to cover the whole of Birmingham and Solihull during 2018/19 and in May 2018 found out we were successful.

We were also involved in the successful bid submitted by the Black Country STP to develop services for its population.

Prevent – our Prevent team held a Prevent conference in March 2018 attended by staff from ours and other trusts as well as third sector organisations. This included speakers from NHS England, Birmingham City Council and local Prevent champions, as well as an ex-paramilitary neo-Nazi and his mentor. The event raised understanding of Prevent and underlined the Trust's leadership in the area of Prevent and mental health. Our Prevent team has had the opportunity to meet both the Home Secretary and Shadow Home Secretary during the year to highlight the impact mental ill health can have on vulnerabilities to extremism and how we respond to and mitigate this.

Primary Care Liaison Service – We are working closely with the CCG's Joint Commissioning Team and partners to develop a Birmingham and Solihull wide Primary Care Liaison Service. Funding for the partnership has been agreed and a 12 month pilot will commence in May, involving partnership working in a number of the highest referring GP practices. It will focus on reducing the number of referrals and re-referrals into community mental health teams, facilitate discharge and reduce rates of non-attendance at Trust appointments. This will also increase mental health awareness, knowledge and understanding for service users.

Safeguarding awareness – in March 2018 our Safeguarding team hosted its third annual partnership learning event entitled 'Simplifying Adult Safeguarding'. The event promoted understanding of safeguarding adults and was co-produced and attended by a range of staff and partner agencies, including the CCG, safeguarding boards, Birmingham City Council and Birmingham Carers. An interactive and innovative live theatre piece by LouDeemy Productions, funded by the Trust charity Caring Minds, was the highlight of the day. This was based on real service user experience to create a very different method of learning.

Learning from deaths – following the publication by the National Quality Board of national guidance, 'Learning from Deaths, a Framework for NHS Trust and NHS Foundation Trusts on identify, reporting, investigation and learning from deaths in care', we have undertaken extensive development of systems and intelligence relating to deaths of service users. This includes establishment of a Learning from Deaths group, approval of a Learning from Deaths Policy, implementation of a mortality case note review process and delivery of two regional masterclasses in mortality. We have been working with key stakeholders such as HM Coroner, with whom the Executive Medical Director and Associate Director of Governance meet bi-monthly to share our approach. We have also continued to work closely with Mazars, helping to inform the national work in this area.

Recovery – since it opened its doors in June 2016 at the Uffculme Centre in Moseley, the Trust's Recovery College for All has built on its success and experience each term, with new sessions being added, co-produced with people with lived experience of mental ill health. The College expanded to Solihull in the spring/summer 2017 term and, after an initial 'did not attend' rate much higher than Birmingham and a subsequent change of venue, this has now improved. Overall 390 people attended 932 Recovery College for All sessions in 2017/18. There are plans to extend to an additional location the north of Birmingham. In addition, a second cohort of Peer Support Workers was trained in July and August of 2017 and a new group of Carer Support Workers is also currently being trained.

Support for families and carers – the families and carers pathway project was initiated to ensure support for those who support our service users, and also that families and carers are appropriately included when planning service users' care. The key deliverables are to ensure that each service user has a carer identified in their clinical record, to offer an in-house assessment plan to carers and signpost them to support services, to include carer's opinions when planning interventions and to evidence all of this. A number of early implementer sites were selected, representing both inpatient and community settings, followed by a phased roll out across the Trust that is due for completion in June 2018. In addition, we have worked with a team of carers to develop a guide for families and carers to support planning for the future and emergency planning. The guide was funded through the Trust's Caring Minds charity and launched at an event in September 2017.

Global Digital Exemplar and Digital Ward – we were named as one of seven mental health global digital exemplar trusts at the end of the last financial year and are working towards a whole range of digital innovations that will help us to increase safety for service users and achieve efficiencies for staff. One part of this is the 'Digital Ward' project, which has seen frontline nurses on wards helping to design, test and roll out a new 'app' to enter therapeutic observations on a hand-held mobile device, replacing written notes and recording essential information in real time and linked to the Trust's electronic clinical record system. This creates more time for direct care. We are now entering the second phase of this programme to design, test and transfer physical observations to this system.

Liaison and Diversion services extended – our service received positive feedback following a visit by the National Health and Justice Lead for NHS England and the Trust has received further resources and budget to enable the team to provide a continuous and extended service into both magistrates and crown courts in Birmingham. We were also chosen as a national pilot site for the application of Mental Health Treatment Requirements which runs parallel to our national pilot sites for crown courts and peer mentors.

Psychological interventions – the Post Graduate Certificate in Low Intensity Psychological Interventions is a course provided by the Trust in collaboration with the University of Birmingham, which trains the psychological wellbeing practitioners of the future. It's the only course of its kind in the Midlands and in September 2017 successfully achieved full accreditation with the British Psychological Society for a further five years, with several commendations. The team has also trained Trust clinical staff in the principles of low intensity psychological work, to enable these evidence based interventions for anxiety and depression to be available to service users within secondary care settings.

Homelessness and mental health – staff from the Trust's homeless primary care and community mental health teams were nominated to join the West Midlands Mayor's taskforce on homelessness. In addition, of our the Trust's senior nurses within the homeless primary care team has been working with the Rough Sleeper Homeless Task Group, alongside police, probation, housing and drug and alcohol services within Birmingham city centre, to support those sleeping rough to move into more stable accommodation and ensure their health needs are met.

Links with local business – the gardens at three Trust sites had a makeover thanks to a link between the Trust's charity, Caring Minds, and Lloyds Bank through its 'Help Britain Prosper Plan'. Lloyds employees were involved as part of the bank's 'Give and Gain Day' volunteer programme to support charities and organisations that are local and personal to them. At David Bromley House, this saw the refurbishment of a relaxing summer house and construction of a practical metal storage shed. Feedback from Trust staff and service users, and Lloyds Bank staff, was equally positive.

Key partnerships and alliances

Since her arrival at the Trust in August 2017, our Executive Director of Strategic Partnerships has been engaging with a wide range of stakeholders and partners to develop a 2030 vision for mental health and priority partnerships for the future. The following priorities have been identified for strategic partnerships:

- Early intervention and recovery through placed based, multi-agency partnerships.
- Partnerships to help safely discharge service users from acute and urgent care.
- West Midlands partnerships.
- Partnerships to improve outcomes for children and young people.
- Partnerships to develop integrated services across drug and alcohol, criminal justice, homelessness and mental health.
- Partnerships that help integrate back office.
- Technology, research and innovation partnerships.
- Commissioning partnerships.
- Partnerships with staff, service users, communities and stakeholders.
- Partnerships to address workforce challenges.
- Partnerships that deliver an economic contribution: working together within mental health to optimise what we can all do to contribute to the local economy.

These will be further developed during 2018/19. Below are some examples of our key strategic partnerships that have seen significant developments during the past year.

MERIT

The Mental Health Alliance for Excellence, Resilience, Innovation and Training (MERIT) is a partnership that involves Birmingham and Solihull Mental Health NHS Foundation Trust working with the other mental health providers in the West Midlands conurbation to improve consistency of care and experience, particularly in relation to crisis care and recovery. It was one of 50 'vanguards' funded by NHS England to develop new models of care and was awarded £1.75m in 2016/17 and the same amount for 2017/18.

MERIT has delivered some significant achievements over the last two years, including:

- development and launch of the initial phase of a crisis care website
- development and introduction of an electronic shared health record viewer
- establishment of a coordinated bed management function across the MERIT trusts supported by an electronic bed viewer
- development of recovery practices with the use of Re-focus and Requol
- delivery of Mental Health First Aid training

- establishment of training passport across MERIT trusts
- joint recruitment activity, shared training and temporary staffing alignment
- establishment of 'time to shine' toolkit providing collaborative support and mock inspections across MERIT trusts.

Central funding for the MERIT programme came to an end in March 2018, but the work will continue and will focus on five key areas over the coming months:

1. Further development of the MERIT Bed Finder, which allows bed managers in the partner trusts to see the status of each other's beds.
2. Adding further data to the innovative electronic health record viewer, so that clinicians have more background on those service users who are seen outside their 'home' trust.
3. Developing the crisis care website to make it a standalone product.
4. Expanding the staff training passport, which allows staff to transfer more easily between jobs in different organisations, and associated work on the skills staff need to work in mental health roles.
5. Working with partners to offer Mental Health First Aid training across the West Midlands.

Reach Out

Reach Out is a partnership of mental healthcare providers in the West Midlands region that was announced by NHS England in July 2016 as one of just four in the country to be successful in a bid to develop a new and innovative model of care for adults in secure mental health services. The three core partners are our Trust, South Staffordshire and Shropshire Healthcare NHS Foundation Trust and St Andrew's Healthcare. From 1 April 2017 the partners took over management of the care budget for adults in secure services across the West Midlands region, which will mean:

- care provided in the least restrictive setting through a new service model of intensive community outreach and wraparound support from a range of partners that will aid recovery, facilitate earlier discharge and reduce the number of readmissions
- more available inpatient beds leading to fewer people being placed out of area away from families and local support networks.

Achievements in the first year of Reach out include the successful funding and recruitment to an enlarged 'FIRST' adult community forensic team, and a substantial increase of in the number of adults supported by these teams in our Trust and South Staffordshire and Shropshire, whilst at the same time seeing a reduction of 10 in the number of people in forensic inpatient care and a commissioning spend below budget.

RAIDplus – NHS Test Bed

Following a successful bid to become one of NHS England's 'Test Bed' sites, we have been working with partners across the West Midlands to build, implement and test digital innovations, supported by redesigned pathways of care, with an aim to reduce both the incidence and intensity of mental health crises. The RAIDPlus team has developed:

- a ‘live’ capacity and demand information system that provides accurate, up-to-date, information to manage patient flow and allocate mobilised specialist staff
- predictive analytics - using completely pseudonymised data, we aim to identify behaviour patterns that help to predict, with a clinically useful level of accuracy, patients who are at the highest risk of experiencing a mental health crisis. Redesigned pathways of care would then help to provide timely interventions to help prevent mental health deteriorating further and avoid individuals experiencing a mental health crisis
- re-designed pathways of care including mobile crisis prevention workers who respond with appropriate care to support the prevention and effective management of mental health crises and a specialised mental health trainer to deliver bespoke training to frontline police, ambulance and community healthcare staff to ensure that anyone who is experiencing a deterioration in their mental health is referred to the right care as soon as possible.

The initial funding was for two years ending in March 2018, and the team was successful in bidding for additional funding from NHS England. This extension will build on the Wave 1 work, completing implementation and fully testing and evaluating the predictive analytics workstream.

Sustainability and Transformation Partnership – Birmingham and Solihull

We have played an active role in the development of the Birmingham and Solihull Sustainability and Transformation Partnership strategy, which outlines five aspirations that the health and social care system stands for:

- independence and resilience
- equity, equality and inclusion
- integration and simplification
- promoting prosperity
- social value.

The refreshed strategy is due to be launched in the first part of 2018/19.

Working together to improve mental health support for young people

Over the last 18 months we have been working with Birmingham Women’s and Children’s NHS Foundation Trust as part of the Birmingham and Solihull Sustainability and Transformation Partnership (STP), to think about how we can improve the experience and lives of young people in need of mental health support, particularly where care pathways cross organisational boundaries, and where increased demand has led to shared challenges. Specific areas of focus include the urgent care pathway for over 18s, and the increasing demand on inpatient beds.

To support this, the two trusts have developed a Memorandum of Understanding which outlines how we intend to work together and what we hope to achieve. This will help to break down barriers and take a more joined-up approach to care across both organisations.

There are a number of areas of work, and initial priorities will be to:

- re-design and implement a single model of urgent care
- deal with system demand and capacity management
- develop a single digital record.

The two organisations are also committed to improving Tier 4 pathways across the West Midlands, using our leadership to influence the development of alternatives to inpatient admission and long lengths of stay.

New funding awarded during the year

We have recently been commissioned to provide a number of services that will ensure high quality mental healthcare for people in Birmingham, Solihull and wider.

- **Recovery Near You:** In partnership with charities Nacro and Aquarius, we have been awarded the contract to continue to provide the Recovery Near You drug and alcohol services in Wolverhampton for at least the next five years. Nacro leads this service and the Trust provides the clinical service, clinical governance and manages GP shared care services and pharmacy.

- **New services:** We have also been successful in bids for two new services. The first is to provide a specialist forensic community mental health service for young people with high risk behaviours such as violence, self-harm and internet offending. This will involve liaising with partners in a range of agencies including child and adolescent mental health services, youth justice, social care, education and third sector providers, and in some cases providing assessment and interventions for the young people themselves. The second new service will focus on caring for veterans with complex mental health problems, including post traumatic stress disorder (PTSD), which are attributable to military service and have not been resolved earlier in their care or support pathway. Both of these new contracts commenced on 1 April 2018.

- **New inpatient beds:** In late 2017, we opened 16 additional new adult acute care beds, which will help to avoid service users having to be sent out of area when they need inpatient treatment, offering a better experience for service users, their families and carers. These were commissioned by Birmingham CCGs following an independent assessment of demand and capacity in the city. Five new low secure inpatient beds for children and young people have also recently opened at our Ardenleigh site, commissioned by NHS England, part of national plans to expand the number of beds for children and young people and help eliminate out of area placements.

Research and Innovation

It has been a successful year for Research and Innovation at the Trust and good progress has been made in developing and implementing new processes, procedures and initiatives to support the delivery of research and innovation across the organisation.

Key developments and achievements include:

- a total income of £2.02m, with a further £99k to support Trustwide innovations
- attracting the highest amount of Research Capability Funding nationally (£171k) although nationally we have slipped to seventh position and have implemented a strategy to increase this in future years
- continuing to support a wide ranging portfolio of research from young people's mental health, to epilepsy, Tourette syndrome and Huntington's disease (HD), bipolar disorders and psychosis and older adult mental health as well as in its key growth areas of dementia and Alzheimer's, secure care and perinatal mental health
- being one of only three UK sites to offer service users access to the IONIS HD trial which is the first human trial of disease modification in Huntington's disease and could lead to the biggest breakthrough in neurodegeneration research in the last 50 years.
- continuing to contribute to the development of clinical guidelines through our research activity and influencing policy on both a national and international basis
- Trust staff producing 91 publications in peer reviewed journals, contributing chapters to books and presenting posters and talks at a number of high profile conferences and events
- actively engaged the Trust's varying services in research, service evaluation and innovation and supporting activities in all four service areas in addition to Trustwide initiatives including electronic prescribing, MERIT, global digital exemplar, Recovery College and spiritual care.
- receiving 38 requests for service evaluation support in 2017/18 compared to 20 in 2016/17 and issuing 23 service evaluation approvals, more than double that of the previous year.
- recruiting 738 participants National Institute of Health Research (NIHR) portfolio studies, exceeding the target of 702 and almost doubling last year's total number
- Health Research Authority approval was provided to undertake research on average within 18 days when the target is set at 40
- recruiting 100 per cent of service users to NIHR portfolio studies within the target of 30 days post approval
- delivering all commercial studies on time and to target and as a result, the department was awarded a 'Highly Commended' acknowledgement at the WM Clinical Research Network's annual awards ceremony
- being the top recruiting organisation to NIHR portfolio dementia studies in the West Midlands
- supporting 105 research teams and individuals across various stages of the research pathway during 2017/18 and approving 33 studies were approved, in addition to pure NIHR portfolio studies
- supporting large innovation projects within the Trust such as RAIDPlus, Reach Out, MERIT and the Global Digital Exemplar, from idea generation and assessment through to development, evaluation and spread
- supporting the West Midlands Academic Health Science Network (WM AHSN) to elevate our Medically Unexplained Symptoms service nationally
- launching a Think Tank initiative which saw staff members come together to discuss their own technological ideas to improve the way we deliver our services across the Trust, with a number of these being supported through our innovation pipeline
- winning awards for Innovative Organisation of the Year and Mental Health Innovation at the WM AHSN's second Celebration of Innovation awards held in July 2017.

- RAIDPlus won the Mental Health Innovation award, Solihull Early Intervention Service was runner up in the MidTech Innovations Award and was awarded £2,000 to support further development or spread of its Silver Linings app.

Financial performance

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

This has been a very challenging year financially both for the Trust and the wider NHS. We were required to make savings of 6.6 per cent while at the same time safeguarding the safety and quality of our services and patient experience. This was against a backdrop of rising inflation and increases in our income of just 0.1 per cent in line with the national tariff inflator. This meant we have had to look carefully at everything we do, and whether things can be delivered in different ways. We also considered how we work with other organisations. We delivered £13.3m of savings against an ambitious plan of £15.1m (88 per cent of the requirement). The balance of £1.8m has been incorporated into plans for 2018/19.

Our year end position is an operational income and expenditure surplus of £5.0m before taking into account any exceptional items, compared to a planned surplus before exceptional items of £2.0m. This included £2.3m of incentive funding from NHS Improvement, which was as a result of outperforming the Trust control target of £2.0m by £695k. The group shows a surplus of £9.4m including exceptional items, as a result of a £4.4m reversal of impairments due to a change in market value on group land and buildings. This item is excluded for reporting the Trust position against its control total.

Consolidated financial performance 2017/18 and 2016/17

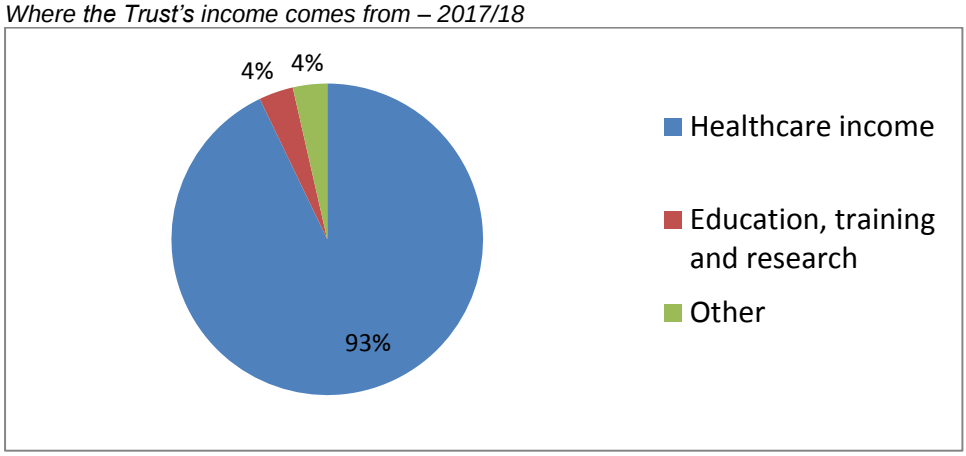
	2017/18 £'000	**2016/17 £'000**
Income from activities	210,765	213,910
Other operating income	24,568	19,848
Total income	235,333	233,758
Operating expenses	(217,271)	(219,814)
EBITDA	18,062	13,944
Capital financing costs	(13,112)	(11,113)
Revaluation/(impairments)	4,368	(33,908)
Profit/(loss) on asset disposal	(15)	(225)
Corporation Tax	72	(3)
Surplus/(deficit) including exceptional items	**9,375**	**(31,305)**
Exceptional items:		
(impairments)/Revaluation	4,368	(33,908)
Costs of exceptional restructuring	0	0
Operating surplus excluding exceptional items	**5,007**	**2,603**
*Control total basis		
Profit/(loss) on asset disposal	0	(225)
(impairments)/Revaluation	4,368	(33,908)
Operating surplus on control total basis	**5,007**	**2,828**
Operating surplus margin	2.1%	1.1%
EBITDA margin	7.7%	6.0%

Income

In the financial year 2017/18 the group generated income of £235m. We had an income inflator applied by our commissioners to our healthcare income contracts of 1.1 per cent. This was in line with all NHS providers.

The chart below shows a breakdown of our income. Most of our income (93 per cent) comes from our local and national commissioners for the delivery of healthcare services. We continue to be a major provider of education and training in the West Midlands and so this represents approximately (4 per cent) of our income.

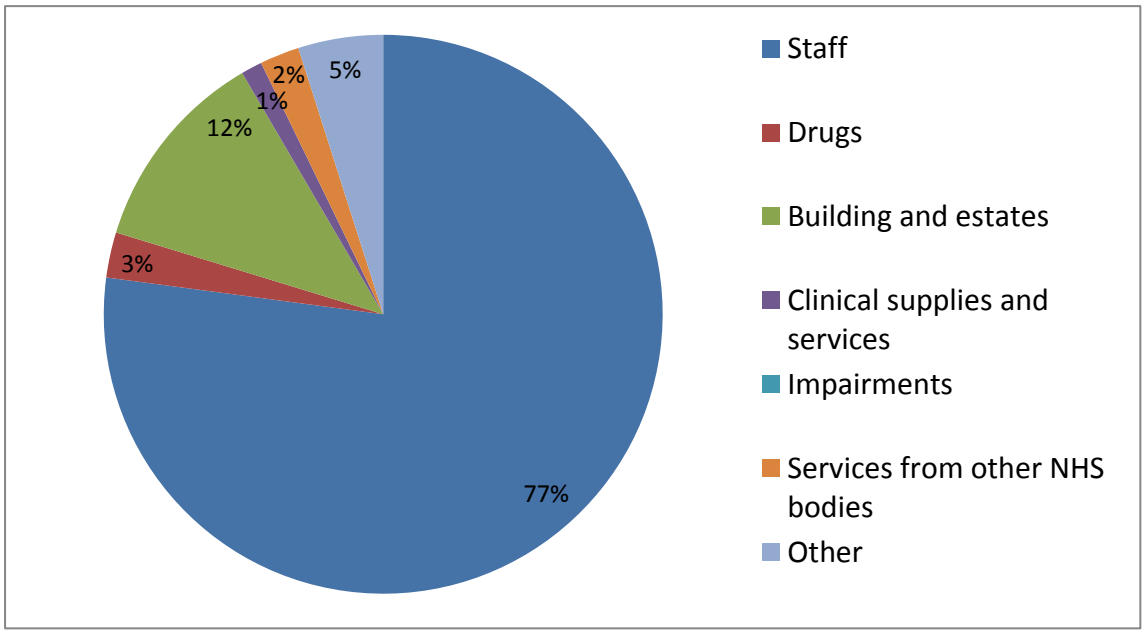
Where the Trust's income comes from – 2017/18



Expenditure

The chart shows that our staff are our most valuable and significant part of our expenditure. However we also operate from over 40 sites across Birmingham and Solihull and the cost of our estate is also a significant proportion of our overall spend. We have reduced our expenditure in year but further work is still needed to fully realise all savings and some plans have been carried forward to 2018/19.

What expenditure was incurred by the Trust – 2017/18



Cash flow

At the end of the financial year we have a cash balance of £17.4m, meaning that our liquidity remains strong. There were no investments made in the financial year as per our Treasury Management Policy as interest rates fell so the investment would have not maximised the interest received from our main Government Banking accounts (GBS).

Overview of capital investment and asset values

We invested £7.4m in our assets in 2017/18. This is comprised of £4.1m in our IT infrastructure and new ways of working, £1.6m in backlog maintenance and ensuring our buildings complied with statutory standards and £1.6m in other projects to modernise our estate and ensure it is fit for purpose.

The year-end revaluation of the group estate which, in line with the previous year, was conducted on a Modern Equivalent Asset (MEA)-alternative site valuation methodology, resulted in an overall reversal of impairments charged to the income and expenditure account of £4.4m and an overall reversal of impairments charged to the revaluation reserve of £8.7m. This exercise does not have an impact on our cash and ensures that the true value of the Trust's assets is recorded in the balance sheet and assists in future financial planning.

How we measure performance

We utilise a range of approaches to report and manage performance for Board members through to supporting operational teams. Examples of existing reports and mechanisms we use include the following:

- Monthly exception based performance report provided to our Finance, Performance and Productivity Committee and Operational Management Team.

- The full key performance indicator (KPI) report includes 41 measures, comprising:

    - national indicators as outlined in NHS Improvement's Single Oversight Framework which was updated part way through the year in November 2017

    - local and commissioner indicators, including the Increasing Access to Psychological Therapies (IAPT) targets agreed with commissioners and local workforce measures relating to sickness absence and compliance with appraisal and fundamental training

    - baseline measures that provide contextual understanding of how services are operating and how service users are progressing along the pathway. The measures reported are those that are generically applicable to Trust services. Examples of measures reported include did not attend (DNA) rates, community mental health team diagnosis recording, services users on the care programme approach (CPA) having a formal CPA review in the last 12 months, service users on caseload with no face-to-face contact recorded in the last six months and emergency readmission rates within 28 days of discharge.

- Weekly operational performance management meetings were in place until December 2017 focusing on staffing and agency, bed management and community services including compliance with national metrics and contractual issues by exception. Following a review by the Trust's Chief Operating Officer and feedback received from operational and corporate stakeholders, a refreshed process was introduced from January 2018. The aim is to maintain a focus on performance metrics and new requirements by exception with the refreshed approach to be undertaken with each service area focusing on the following challenging areas:

    - using data and analysis to better inform demand and capacity
    - understanding the above in conjunction with staff experience
    - triangulating quality, activity and resources as part of the patient experience.

    Service Area Support and Review meetings (SASAR) are now in place with each service area, urgent care services, secure care services, community services and Specialties services being covered on a rotational basis.

- Intranet based reporting on national, commissioning and local priority KPIs as well as providing a library of reports focusing on activity and caseload information, for example length of stay, delayed transfers of care, and organisational reports such as compliance with mandatory training. The reports are refreshed on a daily basis to enable proactive management action by operational and corporate teams. These reports have a drill down facility to enable the reports to be viewed at Trust level, divisional level, team level down to service user level (determined by access rights) to support delivery and improvement.

- Nineteen individual service specific profile reports (SPRs) are now routinely available and refreshed each month to ensure that the data is up to date. These reports provide a 12 month overview of key service user pathway information such as the number of referrals and discharges, DNA and cancellation rates, waiting times for those first seen and for those waiting to be seen. It also includes information about the complexity of the current caseload including diagnosis, cluster, demographic information and workforce information. As well as supporting internal benchmarking the reports enable understanding of service specific activity and how service users are managed across care pathways to inform areas for review and improvement. Issues arising are discussed at operational meetings for action and improvement.

- Utilisation of available external benchmarking reports to provide overall population based context in terms of prevalence and informing local discussions on understanding variation to aid learning and informing the Trust's improvement agenda.

In 2017/18 we have monitored our quality goals of safety, experience and effectiveness against the following indicators:

- Implementation of the positive and proactive care strategy resulting in an environment that is as safe as possible for everyone with reduced incidents of restraint, seclusion and physical violence.
- Reduced mortality through co-produced crisis plans, learning from mortality case note reviews and reduction in suicides.

- Reduction in the number of incidents resulting in harm to service users.
- Reduction in the number of detained service users who fail to return from section 17 leave.
- Improved scores in the National Community Mental Health Survey.
- Experience and involvement of families and carers.
- Implementation of the Trust's physical health strategy.
- Improved communication with GPs.
- Developing and embedding a system of integrated reporting.
- Further development of a quality improvement framework.

We also measure our quality performance through:

- participation in national quality improvement programmes
- our Trust's clinical audit programme
- the Commissioning for Quality and Innovation (CQUIN) payment framework
- Care Quality Commission inspections
- the information governance toolkit
- national quality indicators
- national mental health indicators.

More detail about our quality measures and performance can be found in the quality report section of this annual report.

Environmental matters

Sustainability and climate change 2017/18

With the financial challenges faced by NHS organisations the need to be sustainable in the way in which services are delivered has never been more important.

Recognising this, and in addition to measures already established, we have developed a Sustainability and Climate Change Adaption plan. This challenges us to consider new initiatives that can be introduced to allow services to be delivered in a more sustainable manner whilst at the same time allowing for future planning and futureproofing of resources.

Carbon management

Performance against core sustainability components during the 2017/18 financial year has been strong. Our CO_2 equivalent performance of 10,596 tonnes represents a cumulative reduction of nearly 15 per cent against our 2007/08 baseline.

A breakdown of CO_2 tonnages is as follows:

Year	Electricity, Gas and Oil (tCO_2) - (Taken from properties where actual data is available)	Transport (inc Taxi, Grey Fleet Vehicles and Fleet Vehicles) (tCO_2)	Waste (tCO_2)	Total (tCO_2)
Baseline year of 2007/08 including Waste, Energy and Transport				12,353
2014/15	10,140	848	91	11,064
2015/16	10,139	833	15	10,987
2016/17	9,812	828	9	10,654
2017/18	9,759	828 (data not yet verified for 2017/18)	9	10,596

We are now working towards the next statutory target for CO_2 reduction of a 34 per cent reduction by 2020 (but against a 1990 baseline). The 34 per cent target and 1990 baseline year is a European Union target and not a direct NHS target. NHS trusts need to continue to do what they can and reduce carbon omissions in support of this challenging target, this being despite the fact that many trusts, including ours, do not hold 1990 baseline data as the Trust did not exist at that time.

Waste management (domestic, clinical, electrical and confidential)

Our preferred contractors are very close to achieving zero per cent waste to landfill by both recycling and converting non-recyclable waste into energy via waste to energy recovery incinerators. During the 2017/18 financial year, 98 per cent of the waste was either recycled or sent for energy recovery with only two per cent of all of the waste produced by the Trust going to landfill.

Waste	Non-financial data 2016/17	Non-financial data 2017/18
Total Waste Arising	905 Tonnes	930 Tonnes
Waste sent to Landfill	20 Tonnes	18 Tonnes
Waste Recycled	584 Tonnes	551 Tonnes
% of Waste Recycled / Recovery	98%	98%
Waste Incinerated	301 Tonnes	360 Tonnes

	Financial data 2016/17	Financial data 2017/18
Total Expenditure on waste disposal	£157,502.00	£159,843

From a savings perspective the fairly consistent waste volumes and the competitive prices have seen costs remain effectively static and not reliant on uplift factors.

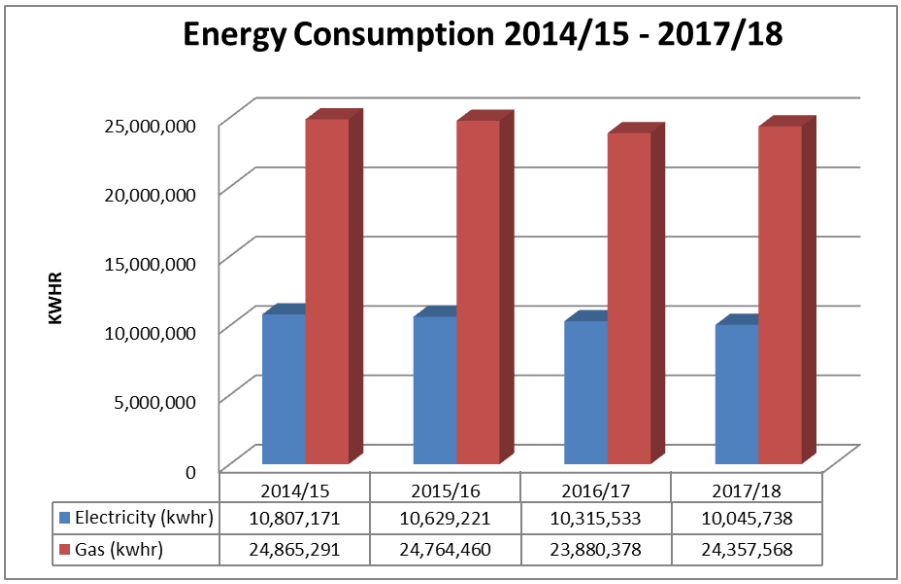
Finite resources (electricity, gas and water)

The table and supporting graphs below demonstrate how:

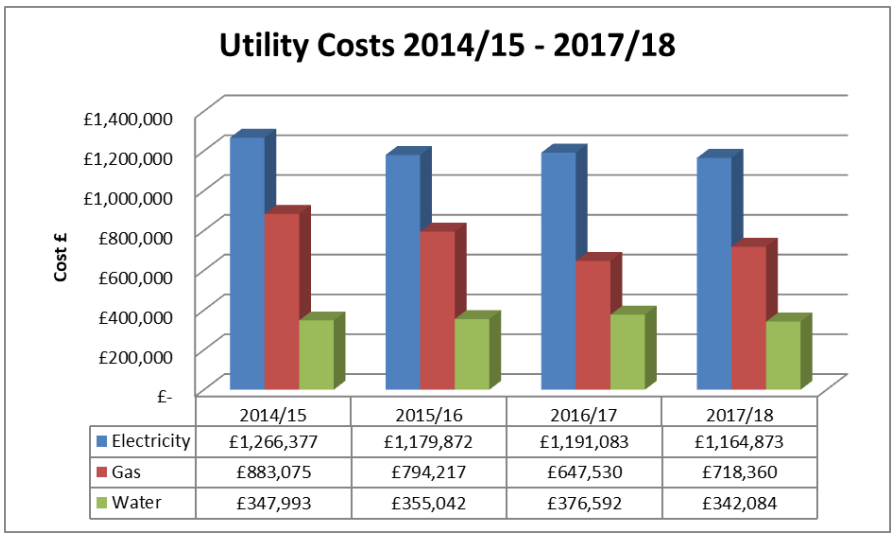
- **Gas consumption** rose in 2017/18 as compared to 2016/17 by two per cent. Meter data and supplier invoices show that this increase was during the abnormally cold spells during the winter. It should be noted that the figures given do not include the compensate given via Met Office degree day data and as such represent core consumption only.

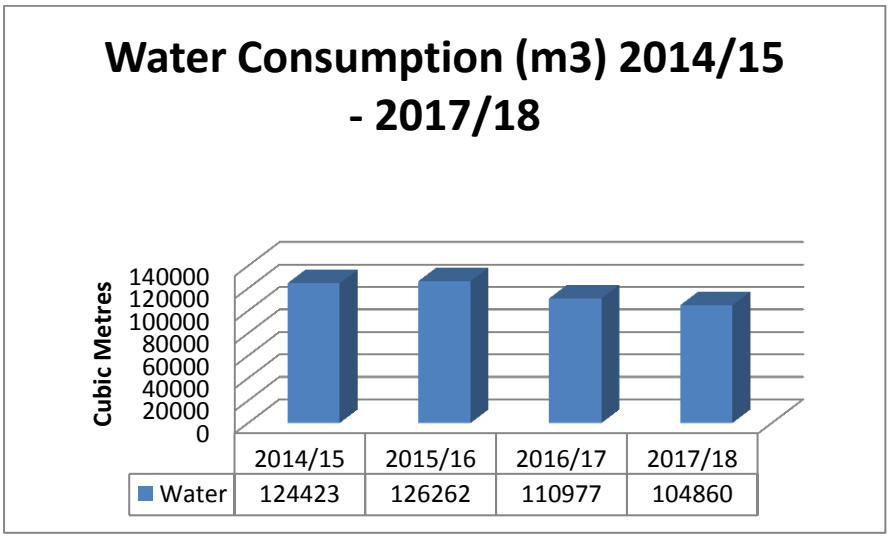
- **Electricity consumption** reduced in 2017/18 as compared to the 2016/17 data by nearly three per cent this being despite the use of additional electric based heating in the very cold spells. This helps to demonstrate the benefits of energy saving interventions such as improved lighting controls and associated LED lighting installations.

- **Energy costs** for 2017/18 were £1.88m, representing an overall increase across the Trust of just one per cent against 2016/17. The reduction in electricity consumption compensated in the most part for gas prices that rose sharply in winter 2017/18 given the unusually high demand across the whole of Europe.



	2014/15	2015/16	2016/17	2017/18
Electricity (kwhr)	10,807,171	10,629,221	10,315,533	10,045,738
Gas (kwhr)	24,865,291	24,764,460	23,880,378	24,357,568





The 2018/19 financial year will be challenging for the Trust as core energy prices for Crown Commercial Service customers are forecast to be in the region of 10 per cent higher than at the end of 2017/18 (mainly due to the non-energy costs associated with levies and availability).

Priorities and achievements

Over the past few years we have made significant progress in addressing the sustainability agenda and have won national recognition and awards in this area. By nature of our success we have already achieved the 'quick wins' and have an opportunity with our Adaption Plan to implement new and innovative measures to help improve further our sustainability credentials.

Recognising the above we need to continue to:

- invest in environmentally efficient and sustainable technologies, products and services
- work in partnership with key stakeholders on promoting 'greener' travel initiatives with a particular focus on the A38 corridor

- integrate and embed the ethos of sustainability within the Estates Strategy and service delivery strategies
- be innovative in the way we continue to drive down resource wastage, continually developing a range of tools and materials to promote its commitment to sustainability, and engaging with staff and service users
- contribute towards the national 34 per cent carbon reduction target by 2020
- implement where feasible the findings and actions with the new Sustainability and Climate Change Action Plan 2017.

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

Social, community, anti-bribery and human rights issues

Community engagement

As the Trust serves a culturally diverse population in various communities across Birmingham and Solihull, it is vital that we engage with the people we serve and work to reduce the stigma surrounding mental health. Our Community Engagement team attends and organises numerous events and are involved in a number of partnerships and initiatives across our communities. Some of the highlights of our work within the community during 2017/18 are summarised below:

- Our Community Engagement and Widening Participation teams worked with the Centre for Mental Health, the Birmingham Repertory Theatre and community organisation First Class Legacy to secure Big Lottery funding for Strengthening the Dial: strengthening the mental health and resilience of black men. This builds on the previous 300 Voices and Up My Street programmes.
- In November 2017 a seminar took place to share information about mental health and the Polish community in Birmingham.
- We worked in partnership The Syrian Vulnerable Persons Resettlement Scheme Partnership Board to deliver Mental Health First Aid training to support the mental wellbeing and mental health needs of Syrian persons settled in Birmingham.
- Our Community Engagement and Spiritual Care Teams supported and participated in a conference in November 2017, organised by Villa Cross Soup Kitchen and Women of Destiny Discipleship Ministries. It explored the prevention and recovery therapies for people living with the effects of mental ill health.
- We took part in the Disability Summit which was hosted by NHS employers in Leeds in May 2017.
- In October the Take Note Conference was delivered as part of the award winning Musical Connections project for vulnerable, isolated and/or disabled adults, including mental health service users. The project is funded by Big Lottery Fund's Reaching Communities Programme and our Trust and is delivered in partnership with Quench Arts.
- Our Chief Executive, John Short, hosted a symposium on the theme of 'The impact of sexual violence on victims, and how to treat their trauma - lessons from the Bosnian conflict and implications for our services' in October 2017.

- In October the Trust held a seminar on the Irish community in Birmingham. The seminar was a valuable opportunity to learn more about this somewhat 'invisible' community.
- The Bedlam Festival took place in October at the Midlands Arts Centre and the Birmingham REP.
- As in previous years, during summer 2017 five community engagement events were held at Trust sites across Birmingham and Solihull, helping to engage local communities and challenge stigma.

Anti-bribery

We are committed to full compliance with the Bribery Act 2019 and have a zero tolerance approach to bribery and corruption, undertaking due diligence on third parties with whom we work to ensure they have high ethical standards and our reputation will not be compromised by our association with them. Our latest Counter Fraud and Anti-Bribery Policy was ratified in April 2016 and established a framework that:

- improves the knowledge and understanding of everyone in the Trust, irrespective of their position, about the risk of bribery and its unacceptability
- assists in promoting a climate of openness and a culture where staff feel able to raise concerns sensibly and responsibly;
- sets out the Trust's responsibilities in terms of the deterrence, prevention, detection and investigation of bribery and corruption
- ensures the appropriate sanctions are considered following an investigation.

This policy works in conjunction with the Declarations Policy which provides guidance on the process to be followed should sponsorship, gifts and/or hospitality be offered to any member of staff by commercial organisations or generally in the course of the performance of their duties.

Human rights

The Human Rights Act underpins the requirements of the NHS Constitution and speaks directly to the requirements for Freedom, Respect, Equality, Dignity and Autonomy to be provided to all. Our induction training programme has included an introduction to human rights since November 2013, and this is also part of the equality and diversity e-learning programme that was introduced in 2014/15. Our Equality Analysis Guidance and Assessment Tool gives consideration to human rights and the tool forms part of the our project management system. We have a Human Rights Act and Equality Act policy that promotes enjoyment of human rights; this includes the human rights of those service users who are detained under the Mental Health Act. Protection of the human rights of staff is covered in the Equal Opportunity in Employment Policy.

Promoting Human Rights remains a key focus for the Trust, as part of this work our community engagement team invited a series of speakers to our Trust to hear about their work on equality, diversity, human rights and inclusion.

Peter Tatchell**,** who has worked for over 40 years challenging stigma, prejudice and intolerance in the field of race equality, disability rights, LGBT freedoms and global injustices, was the first of these speakers.

He spoke to our staff, service users and guests about how those who are socially disadvantaged are often the ones who struggle most with their mental and physical health as they are often living with the stress of intolerance and prejudice.

Equality, Diversity and Human Rights Week took place from 15 to 19 May 2017. The theme for this year was diverse, inclusive, together. A range of events open to staff, users and carers and the general public were organised that included workshops on transgender awareness, forced marriage, female genital mutilation, and spirituality and hope. A marketplace was held featuring stalls representing different strands of equality. There was also a session with Stephen Frost, globally recognised diversity, inclusion and leadership expert. The event was well attended by Trust Board members and staff allowing an open and honest discussion around where we are as a Trust and what more needs to be done around inclusion.

In March 2018 Jane Garvey, BBC Woman's Hour presenter, came to the Trust to discuss gender equality with an audience of staff, stakeholders and service users.

Important events since the end of the financial year

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

Overseas operations

The Trust has no operations outside of the UK

Signed:

John Short, Chief Executive
Birmingham and Solihull Mental Health NHS Foundation Trust Date: 23 May 2018

Accountability report

Directors' report

Our Board of Directors (the Board) attaches great importance to ensuring that we operate to high ethical and compliance standards. In addition it seeks to observe the principles of good corporate governance set out by the NHS Foundation Trust Code of Governance.

The Board is responsible for the management of the Trust and for ensuring proper standards of corporate governance are maintained. The Board accounts for the performance of the Trust and consults on its future strategy with its members through the Council of Governors (COG).

The Council has a role in influencing the strategic direction of the Trust so that it takes account of the needs and views of the members, local communities and key stakeholders, to hold the Board to account on the performance of the Trust, to help develop a representative, diverse and well-involved membership and to help make a noticeable improvement to the service user experience. It also carries out other statutory and formal duties, including the appointment of the Chair and non-executive directors and appointment of the external auditor.

Meet the Board

The section below outlines members of the Board who at any time during 2017/18 were directors of the Trust.

Sue Davis CBE, Chair

Sue Davis CBE was appointed Chair in November 2011, having previously served in the same role at Sandwell and West Birmingham Hospitals NHS Trust from June 2006. Sue has extensive experience in the governance of public bodies, beginning in 1981 at Shropshire County Council. She spent 26 years as an elected councillor, including four years as County Council Leader, and for 10 years represented UK local government at the Congress of Local Authorities at the Council of Europe. She has worked on regeneration bodies, and on the regulatory body for UK Civil Tribunals, and served a term as Chair of a national charity. Her service in the health sector has included membership of a Health Authority, and chairing Telford PCT for its first four years. Since 2013, Sue has represented mental health trusts on the Board of NHS Providers, where she is Vice Chair. Sue also serves as Independent Chair of the Audit Committee at West Midlands Police, and is a member of the Chapter of Birmingham Cathedral.

John Short, Chief Executive

John Short has been Chief Executive of the Trust since 1 April 2013. He has been at the forefront of the Trust's work to improve staff, service user and carer engagement and demonstrate a real Trustwide focus on service quality. He began his career as a mental health social worker with local authorities and worked in a number of different settings, before moving onto mental health services management in the NHS over 20 years ago. John has worked in a number of trusts providing services ranging from inner city to rural services. He has held a number of posts including Senior Manager Mental Health Services at the West Midlands Regional Office, Director of Mental Health and Learning Disability Services in Shropshire, Chief Operating Officer at Cheshire and Wirral Partnership Foundation Trust and Director of Change Programmes and Chief Operating Officer in Leicestershire. His first CEO post was as interim Chief Executive of Leicestershire Partnership Trust from 2011 until his appointment in Birmingham and Solihull. John has led numerous service and organisational changes in his career, including steering many mental health services in their move from care in impersonal large asylums to care that is increasingly community and person-centred and compassionate.

Charlotte Bailey, Executive Director of Strategic Partnerships (appointed 1 August 2017)

Charlotte Bailey joined the Trust as Executive Director of Strategic Partnerships in August 2017. Charlotte is an experienced strategic leader and has spent over eight years at director level in senior teams. She was previously an executive director with Sefton Council in Merseyside, an organisation with 3,500 employees and a £200m annual budget. Charlotte played a key role in the development of the Sefton 2030 vision and Sefton Partnership Pledges. This involved removing duplication and prioritising resources, re-defining the core purpose of the council and setting a three year budget. As a commissioner of outcomes, leader of services, manager of people and innovator of creative solutions, Charlotte has a track record of implementing strategies, plans and solutions whilst demonstrating results and delivering continuous improvement. She has a good understanding and experience of working with the NHS, having worked with health commissioners and providers throughout her career.

Prof Russell Beale, Non-Executive Director

Prof Russell Beale joined the Trust as a non-executive director on 1 January 2017, a role he also holds at Walsall Healthcare NHS Trust. He has a wealth of experience from his 25 years at the University of Birmingham, where he is currently Professor of Human-Computer Interaction (HCI) and Director of the HCI Centre, a major centre focusing on designing and developing the digital future. Prof Beale has achieved worldwide recognition for his work on using artificial intelligence to assist interaction between users and technology, is a Chartered IT Professional and Visiting Professor at the University of Swansea. He also has commercial and management experience, having held senior positions in both large and small technology organisations and founded six hi-tech companies.

Dr Hilary Grant, Executive Medical Director

Dr Hilary Grant was appointed Executive Medical Director on 1 April 2016. Hilary is responsible, among other things, for medical, psychology and pharmacy leadership at the Trust. Hilary has been with the Trust for over 20 years, and was a clinical director for three years prior to her appointment to the Board. She played a significant role in the development and opening of the Trust's Forensic Child and Adolescent Mental Health Service (FCAMHS) in 2003 and has undertaken extensive service development and re-design which led to the service being shortlisted for an HSJ award in 2010, winning a National Patient Safety Award in 2011 and being the first unit in the country to be accredited by the National Autistic Society in 2012. Hilary is a tireless advocate for service user empowerment and raising standards of care in Forensic Child and Adolescent Mental Health Services.

Sue Hartley, Executive Director of Nursing

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

Brendan Hayes, Chief Operating Officer/Deputy Chief Executive

Brendan joined the Trust as Executive Director of Operations on 15 July 2013. As a qualified nurse with a strong mental health and operational management background, Brendan has a wealth of experience gained in a number of senior NHS roles. Prior to joining the Trust he was Director of Operations and Nursing at Northamptonshire Healthcare NHS Foundation Trust.

Barry Henley, Non-Executive Director

Dr Barry Henley has been a non-executive director at the Trust since 1 July 2013, a role he has previously held at Heart of Birmingham teaching PCT and the Birmingham and Solihull NHS Cluster. Barry brings a wealth of experience and expertise in private industry and the public sector to our Trust. He was Chief Executive of Chubb group companies in the UK, Singapore and Australia, before becoming Chief Executive of the faculty of engineering and computing at Birmingham City University. He was subsequently a knowledge transfer partnership advisor on dozens of innovation projects for the Technology Strategy Board.

Barry is also a councillor representing the Brandwood ward on Birmingham City Council and he chairs the Council's conservation and heritage panel, the wholly owned subsidiary Acivico, the ICT joint venture with Capita and the Standing Advisory Council on Religious Education.

Gianjeet Hunjan, Non-Executive Director

Gianjeet Hunjan was appointed as non-voting Associate Non-Executive Director on 1 September 2015 and was appointed as Non-Executive Director in September 2016. She is a qualified accountant with extensive experience in the NHS and education sector. Her background includes working at director level in a variety of healthcare roles for over 20 years. She is a Chartered Accountant and has a Master of Arts in Finance and Accounting from Leeds Metropolitan University.

Waheed Saleem, Non-Executive Director

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

Dave Tomlinson, Executive Director of Finance (appointed 1 April 2017)

Dave Tomlinson joined the Trust as Executive Director of Finance in April 2017. Dave brings 20 years' experience as a Director of Finance in the NHS, the vast majority of which has been with large mental health providers. He plays a key role in advising the Board on issues around the Trust's fiscal performance, information governance and estates. Dave's experience includes 12 years as Director of Finance at Lancashire Care NHS Foundation Trust where he established the Trust as a £100m turnover provider by bringing together services from seven organisations, led the acquisition of a number of services and established a commercial and property management joint venture that delivered savings of £1m per annum. He has experience in both the private and public sector and during his career has been responsible for a broad portfolio of services in large and complex organisations. Most recently he has enjoyed a successful period as an interim director in acute and mental health trusts.

Joy Warmington, Non-Executive Director (Vice Chair)

Joy Warmington is a Non-Executive Director of the Trust and Chair of the Integrated Quality Committee. She is also CEO of BRAP, successfully guiding the organisation to its cutting edge position where it is nationally recognised for producing innovative equalities and human rights research and strategies. A former lecturer with an MSc in Organisational Development and Management Learning, Joy has written and co-authored over 20 books, articles, and reports on subjects as diverse as implementing organisational change, improving public sector engagement practice, and using human rights to improve service delivery. In addition to advising the Department of Health on health inequalities, Joy's services have also been sought by Macmillan Cancer Support, the Care Quality Commission, the Equality and Human Rights Commission, Barts Health Trust, University Hospital Southampton Foundation Trust, Sheffield Trust, and many others. Joy is regularly asked to comment on equalities issues in the media, most recently appearing in the Economist, Daily Telegraph, and Health Service Journal in addition to numerous appearances on BBC radio and television. Joy is also Vice Chair of the Trust.

Dr Nerys Williams, Non-Executive Director (Senior Independent Director)

Dr Nerys Williams - who was appointed as a Non-Executive Director on 1 December 2011 - is a qualified doctor specialising in the field of occupational health medicine. She has worked in both clinical, regulatory and strategy/health policy roles including work for Health and Safety Executive and Department for Work and Pensions. Outside of the Trust, Nerys holds a number of roles relating to her professional qualifications in the NHS, local government and education fields. Nerys acts as Chair of the Charitable Funds Committee for the Trust and is also Senior Independent Director.

The biographies above provide an outline of the skills, expertise and experience of Board members. This demonstrates the breadth required of a foundation trust, including all statutorily required roles. The balance of the Board is considered when new appointments are made. During the course of the year the Trust appointed a new Executive Director of Strategic Partnerships and a new Executive Director of Finance to replace the previous Executive Director of Resources who left the Trust in March 2017.

The Board meets regularly and has a formal schedule of matters specifically reserved for its decision. This includes high level matters relating to strategy, business plans and budgets, regulations and control, annual report and accounts, audit and monitoring how the strategy is implemented at an operational level.

The Board delegates other matters to the executive directors and senior managers as appropriate. During the course of 2017/18 the Board met formally 10 times. Attendance is provided in the table below. Committee meetings take place between Board meetings. The directors have access to all relevant management, quality, financial and regulatory information.

Trust Board attendance 2017/18

Dates	26/04/17	31/05/17	28/06/17	26/07/17	27/09/17	25/10/17	29/11/17	31/01/18	28/02/18	28/03/18
Sue Davis	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
John Short	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Brendan Hayes	✓	O	✓	O	✓	✓	✓	✓	✓	✓
Hilary Grant	✓	O	✓	✓	✓	✓	✓	✓	✓	✓
Dave Tomlinson (joined April 2017)	✓	✓	O	✓	✓	✓	O	✓	✓	✓
Sue Hartley	✓	✓	✓	O	✓	✓	✓	✓	✓	O
Charlotte Bailey (joined August 2017)					✓	✓	✓	✓	✓	✓
Nerys Williams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Joy Warmington	✓	✓	✓	O	✓	✓	O	O	✓	✓
Barry Henley	✓	O	✓	✓	✓	✓	✓	✓	✓	✓
Waheed Saleem	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gianjeet Hunjan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Russell Beale	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

O = apologies given ✓ = attended meeting
P = part of one of the meetings (public or private) missed

Each member of the Trust Board is subject to an annual appraisal. For the Chair this is conducted by the Senior Independent Director, Nerys Williams, and the Lead Governor. For non-executive directors it is led by the Chair of the Trust and assisted by a member of the Council of Governor's Nomination and Remuneration Committee. Feedback is obtained from various sources to contribute to the discussion. The previous year's objectives are reviewed as well as the feedback in order to inform a discussion about the objectives going forward.

For the executive directors they are subject to regular one-to-one meetings at which their performance is evaluated and discussed and annual appraisals take place with the Chair for the Chief Executive and with the Chief Executive for the rest of the executive team, which are reported to the Remuneration Committee. On an annual basis, the Chair of the Trust meets with each Board member to consider their personal contribution to the performance of the Board.

Appointment, re-election and the Nominations and Remuneration Committee

The Chair leads the process to identify the size, structure and skills required for the Board and for considering any changes necessary or new appointments. If a need is identified, in the case of an executive director this would be managed through the Remuneration Committee and for non-executive directors through the Nominations and Remuneration Committee.

During the 2016/17 financial year, the Remuneration Committee agreed to the recruitment of an additional executive director role focusing on strategic partnerships and this new director joined the Trust on 1 August 2017.

The Executive Director of Resources left the Trust at the end of March 2017. Her successor David Tomlinson, joined the Trust on 1 April 2017.

The Chair, Sue Davis, was appointed for a third term of office by the Council of Governors in March 2017. This was effective from December 2017 which is when her previous term of office came to an end. This will be reviewed after two years.

Register of interests

The register of interests for directors and for governors can be obtained by contacting the Company Secretary, Unit B1, Trust HQ, 50 Summer Hill Road, Birmingham, B1 3RB or by telephoning 0121 301 1096. The registers are regularly updated and presented to the Board and Council of Governors.

Company Secretary

The Board has direct access to the advice and services of the Company Secretary who is responsible for ensuring that the Board and committee procedures are followed and for advising the Board, through the Chair, on corporate governance matters.

Board committees

During 2017/18 the Board had the following committees:

- Audit Committee
- Integrated Quality Committee
- Charitable Funds Committee
- Finance, Performance and Productivity Committee
- Mental Health Legislation Committee
- Remuneration Committee.

Details of these committees are included in the annual governance statement.

For each individual committee, there is a requirement for it to evaluate its performance on an annual basis, to report this to the Trust Board and to provide an annual report on its activities to the Audit Committee. The Trust has also had an evaluation of its quality governance undertaken in the reporting period by its internal auditors.

Membership of the Audit Committee

The Audit Committee is responsible for oversight and assurance that the processes undertaken by the Trust and other committees are operating effectively.

The membership of the Committee during the reporting period was:

- Gianjeet Hunjan - Chair – Non-Executive Director
- Barry Henley - Deputy Chair - Non-Executive Director
- Nerys Williams - Non-Executive Director
- Waheed Saleem - Non-Executive Director
- Russell Beale - Non-Executive Director

The Executive Director of Finance and Company Secretary are required to attend. Non-executive directors who are not members of the Committee may attend with the agreement of the Chair of the Committee. Executive directors are encouraged to attend when the Committee is discussing operational issues or areas of risk that are the responsibility of that director. The Chief Executive is invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control. Appropriate internal and external audit representatives normally attend meetings, although they are not entitled to vote. At least once a year the Committee meets in private with the external and internal auditors.

Audit Committee Attendance 2017/18

Date	April 2017	May 2017	July 2017	Sep 2017	Nov 2017	Feb 2018
Gianjeet Hunjan	✓	✓	✓	O	✓	✓
Barry Henley	✓	✓	✓	✓	✓	✓
Nerys Williams	✓	✓	O	✓	✓	✓
Waheed Saleem	O	✓	✓	O	✓	✓
Russell Beale	✓	O	✓	✓	✓	✓

O = apologies given ✓ = attended meeting P= partial

The Audit Committee has a work plan which considers various areas as follows:

- Internal audit reports and annual plan.
- Review of internal and external audit and local counter fraud effectiveness.
- Counter fraud annual report and updates.
- Trust losses and special payments.
- External auditor's plan and updates.
- Annual governance statement.
- Board assurance framework and risk register.
- Review of audit committee effectiveness.

Trust auditors

The Council of Governors re-appointed PricewaterhouseCoopers LLP (PwC) as external auditors of the Trust for the three years commencing 2014/15 following a competitive tender exercise. The contract was extended for a further two years and there will be a procurement process to appoint auditors beyond this period. The audit fee for the year ended 31 March 2018 was £49.7k for the Trust's annual report, £7.3k for the Trust's quality accounts, £3k (2016/17: nil) for additional payroll controls and new models of care and £8.8k for Summerhill Supplies Limited totalling £65.8k excluding VAT (compared to £63.6k for the year ended 31 March 2017). This was the fee for an audit in accordance with the Audit Code issued by NHS Improvement in December 2014.

In addition to the audit of the financial statements, PwC also provided non-audit work in previous years (ie corporation tax work for our subsidiary). In 2017/18 as part of the new Auditor Guidance Note there is now a list of prohibited non-audit services, which includes tax services relation to the preparation of tax forms and provision of tax advice. Under the new legislation these services are prohibited.

The following threats and safeguards are in place to ensure Auditor objectivity and independence. PricewaterhouseCoopers LLP does not support the Company in making/negotiating any changes/contract/disputes with other parties.

The Audit Committee carries out a review of the effectiveness of the external auditor following the completion of each annual audit, assessing the external auditor's performance against an agreed framework and seeking the views of officers of the Trust, and reports the outcome of that review to the Council of Governors, together with a recommendation as to whether the external auditor should be re-appointed for the following year (depending on the length of the contact in place).

The role of internal audit

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

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

Plans are based upon a risk assessment, which ensures the programme reflects key risks faced by the Trust, cross referenced to the Trust's Board Assurance Framework. TIAA uses a business risk model to assess and understand a wide range of risks, and inform our plan. Key areas include:

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

Plans consider the national context of the health economy and current developments in the regulatory environment. This includes changes in the Care Quality Commission's assessment framework. Internal Audit has held discussions with Trust senior management to support them in developing their audit plans.

It has also reviewed the work that has been undertaken over the previous three years, to inform the development, and the outcome of those reviews.

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

Significant issues considered by the Audit Committee in relation to the financial statements

Asset valuations

The Trust is in the process of transferring the Reaside medium secure facility to its wholly-owned subsidiary, Summerhill Supplies Limited. As at 31 March 2018, Reaside is valued as an asset held for sale in the books of the Trust. It is valued in the Group accounts as an ongoing asset with a 27-year life. There had been ongoing discussion with the District Valuer and PwC regarding this treatment. There was debate as to whether the treatment was appropriate given the clear view within the Trust's estate strategy and capital programme and the Birmingham and Solihull STP estate strategy that Reaside needed to be replaced or reprovided within the next five years. As it is clear that there is no external driver meaning that the Trust had to replace Reaside, it was accepted that the appropriate valuation and asset life were those advised by the District Valuer.

Reach Out income

The Trust is responsible, in partnership with St Andrews Healthcare and South Staffordshire and Shropshire Healthcare NHS Foundation Trust, for the commissioning of secure inpatient services for West Midlands residents as one of the New Care models. There had been lengthy debate throughout 2017/18 nationally regarding the appropriate accounting treatment. Because of the way that the contracts had been designed when the New Care Models programme had been established, the direction of NHS England and the Department of Health is that the Trust is an agent of NHS England in this respect and the appropriate treatment is to account for the net income, i.e. the difference between the overall financial envelope and the costs of provision. This might change as the New Care Models move from pilot to business as usual status, but this does not impact on 2017/18. The Audit Committee considered and debated this position and accepted the advice of the auditors, which was consistent with other New Care Models elsewhere in the country.

Managing public money

The Trust has complied with HM Treasury's guidance 'Managing Public Money'. Which sets out the steps public bodies should take where they have caused injustice or hardship by maladministration or service failure.

This includes setting up systems for dealing with complaints promptly and consistently, setting out what remedial measures are needed to resolve issues and reporting ex-gratia payments to those charged with governance and the annual account.

The Trust has complied with the cost allocation and charging requirements as set out in the HM Treasury and Office of Public Sector Information guidance.

Political donations

We have not made any political donations in 2017/18.

Better payment practice code

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

Better Payment Practice Code performance

	2017/18	2017/18	2016/17	2016/17	2015/16	2015/16	2014/15	2014/15
	Number	£'000	Number	£'000	Number	£'000	Number	£'000
Total NHS invoices paid in the period	498	9,805	529	10,053	521	8,726	555	9,198
Total NHS invoices paid within target	484	9,644	515	9,903	474	8,403	508	9,044
Percentage of NHS invoices paid within target	97.2%	98.4%	97.35%	98.51%	90.98%	96.30%	91.5%	98.3%
Total non NHS invoices paid in the period*	35,557	84,885	25,455	91,931	56,875	58,559	52,315	53,300
Total non NHS invoices paid within target	33,392	83,409	33,915	90,500	53,321	53,655	47,194	48,366
Percentage of non NHS invoices paid within target	95.4%	98.3%	95.66%	98.44%	93.75%	91.61%	90.2%	90.7%

*The total number of invoices has decreased since 2015/16 as many suppliers now invoice on a consolidated basis.

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

Nil interest was paid under the Late Payment of Commercial Debts (Interest) Act 1998. This was also nil in 2016/17.

Fees and charges (income generation)

There was no income and full cost associated with fees and charges levied by the Trust, where the full cost exceeds £1m or the service is otherwise material to the accounts, to disclose for the financial year.

Income disclosures

The Trust has met the requirement under section 43(2A) of the NHS Act 2006 that the income from the provision of goods and services for the purposes of the health service in England is greater than the income from the provision of goods and services for any other purposes. Under section 43(3A) of the NHS Act 2006 the Trust's other income that has been received has not had a significant impact on its provision of goods and services for the purposes of the health service in England.

Statement of compliance with the NHS Foundation Trust Code of Governance

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

The Board of Directors considers that it was compliant in 2017/18 with the provisions in the revised NHS Foundation Trust Code of Governance including the requirement that all non-executive directors should be considered as independent. The Council of Governors retains the power to hold the Board of Directors to account for its performance in achieving the Trust's objectives.

The Trust Board, through its committees, received information in respect of quality of delivery of services, financial and other performance in order to ensure and measure its effectiveness, efficiency and economy.

During 2014 significant work was undertaken in ensuring that relevant strict measures and milestones had been developed and were being monitored to assess performance by progress and delivery performance. This was strengthened during 2015/16 and 2016/17 and continued into 2017/18, with a greater level of information now available at service line level.

The Chief Executive has not had to adopt any procedure or advise the Board or Council of Governors about any objections to decisions during the reporting period.

The Trust Board has a constitution and standards of conduct of all standing orders and scheme of delegation for the Trust, which includes the Nolan principles setting out the accepted standards of behaviour in public life. The Trust Board therefore requires all of its members to operate to a code of conduct building on the Nolan principles reflecting high standards of probity and responsibility.

During the reporting period, all members of the Board have been required to confirm that they are fit and proper persons in accordance with both NHS Improvement's provider licence and CQC requirements and the Duty of Candour applies to all staff. During the year over 200 senior staff were written to by the Company Secretary Department seeking annual declarations. At the time of writing a small number remained outstanding. This was reported to the March 2018 Audit Committee and these declarations are being formally pursued.

The Trust has appropriate insurance in place to cover the risk of legal action against its directors.

The process is well established for recruitment of non-executives via the Nominations and Remuneration Committee, which leads the process supported by external advisors where required as well as the Company Secretary. We have a matrix of Board composition and this would be used to inform the decision on the skills and experience that are required for any post. During the reporting period, the Committee agreed that the terms of office for the Chair and other Non-executive Directors are for three years. Generally speaking, a Non-executive Director will serve no more than two terms of three years (a total of six years). However, consideration will be given to a proposed third term of office provided that, and in line with the Code of Governance, this has been subject to rigorous review with a clear rationale for doing so and the decision to extend made by the Council of Governors, taking into account the needs of the organisation. This does not impair the ability of the Council to remove non-executive directors, where appropriate, at any given time or to consider any issue related to perception around 'independence'. It was also agreed that the Chair should serve a third term. There was a process in place to undertake the annual review of the performance of the Chair and non-executive directors and the process for 2017/18 was approved and has been followed.

Council of Governors and membership

Governance of a foundation trust is prescribed by legislation, to comprise members, governors and the Board of Directors. The members may be service users, carers, staff or the general public who have an interest in the Trust and its work. The Council of Governors includes appointed governors from stakeholder organisations and elected governors to represent public constituencies, service users, carers and staff. The constitution outlines the key statutory responsibilities of the Council of Governors.

Composition of the Council of Governors

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

Role and responsibilities of the Council of Governors

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

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

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

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

The Council may not delegate any decision-making or executive powers to any committee or sub-committee.

Standing Orders for the Council of Governors and the Board of Directors are in the Constitution which is available on the Trust's website.

The specific role of Trust governors

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

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

Governors are a key link with the communities our Trust serves, who feed back to the Board on issues their constituents feel need to be addressed, as well as ideas for service development or improvement.

Part of their role is to ensure the views of service users, stakeholders and local communities are taken into account when plans for services are being drawn up. They are also ambassadors for the Trust who champion initiatives to tackle the stigma associated with mental illness.

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

A report to the Council of Governors meeting was received on 13 March 2014 which detailed aspects of the Monitor Code of Governance, roles and responsibilities and how any disagreements should be resolved, as well as who should take different types of decisions. This is available on the Trust website. In terms of dealing with any disagreements, if at any point the Council of Governors has any concerns about engagement with the Board of Directors, they should raise these in the first instance with the Chair of the Trust. The Council of Governors may require any director to attend a Council of Governors meeting, although this would normally be discussed in the first instance with the Lead Governor, Senior Independent Director and Chair. In exceptional circumstances, NHS Improvement has established a panel for the advising of governors. Questions raised to this panel by the governors will only be addressed if it relates to whether a Trust has failed or is failing to act in accordance with its constitution or to act in accordance with Chapter 5 of the NHS Act 2006. Prior to referring a question to the panel more than half of the members of the Council of Governors voting must approve the referral and the panel will required evidence of this voting process prior to considering a question. A section on management of disagreements was added to the constitution in 2016.

All governors have confirmed that they meet the criteria as prescribed by our licence.

It is acknowledged that there is an expectation on governors that they canvass the opinion of Trust members, and for the appointed governors the body they represent, on the Trust's objectives, priorities and strategy, in order for their views to be shared with the Board. During the course of the year governors participated in joint strategy sessions with the Board. Regular updates have been provided to the Council of Governors on progress with implementation of the Membership Engagement and Governor Involvement Strategy.

The non-executive directors and the governors meet regularly, including joint Board/Council meetings and where possible non-executive directors attend Council of Governors meetings. Governors have had an open invitation to attend both the public and private Board meetings and have opportunities to ask questions. Governor representatives observe the non-executive chairs of Board sub-committees as part of the annual appraisal process.

Executive directors usually attend Council of Governors meetings and non-executive directors have an annual objective relating to attendance at Council of Governors meetings. In addition, the Trust Board works closely with the Council of Governors and invites the Council of Governors to attend both public and private Board meetings to develop relationships between Board members and governors.

Members can contact their governor by sending email messages to daniel.conway@nhs.net, calling the Membership Support Officer on 0121 301 1096, or by writing to the governor c/o: Governor Liaison Office, Birmingham and Solihull Mental Health NHS Foundation Trust, 50 Summer Hill Road, Birmingham, B1 3RB.

The Council of Governors has not exercised its power under paragraph 10c of schedule 7 of the NHS Act 2006.

Lead Governor

The Council of Governors votes in one of its elected members to be the Lead Governor. Governors will generally communicate with NHS Improvement via the Chair or Company Secretary, however there may be instances where it would not be appropriate to do so and in such circumstances it would be the Lead Governor who would communicate with NHS Improvement.

The current Lead Governor is Service User Governor, Faheem Uddin.

Governor elections in 2017/18

There were four election processes held in the financial year for the following roles:

- Peter Brown – Service User Governor, Solihull – elected through a contested election in January 2018.
- Dr Felicia N. Orlu – Staff Medical Governor – elected unopposed in August 2017 and stepped down in March 2018.
- Hazel Kench – Public Governor, Solihull – re-elected unopposed in August 2017.
- Anthony Brookes – Carer Governor – re-elected unopposed in January 2018.
- Michelle Long – Carer Governor – re-elected unopposed in January 2018.

The Council will be considering options with regard to unfilled posts that have proved difficult to recruit to. Further effort is taking place on how best to full the Public Governor for the Rest of England and Wales.

During the course of the year the following appointed governors stepped down and were replaced by their organisations:

- Michael Adams (Birmingham City University) – appointed September 2015, stepped down September 2017, replaced by Jim Chapman in September 2017.
- Joanne Fairburn (Solihull Metropolitan Borough Council) – appointed July 2016, stepped down July 2017 and replaced by Councillor Alan Rebeiro in July 2017.

Our governors 2017/18

All governors are elected/appointed for a three year term.

Public Birmingham
Khalid Ali – elected in November 2014, re-elected unopposed in November 2017
Robert Dalziel – elected in November 2014, re-elected unopposed in November 2017
Philip Jones – elected unopposed in November 2014, elected unopposed in November 2017

Public Solihull
Hazel Kench – elected in August 2014, re-elected unopposed in August 2017

Public rest of England and Wales – currently vacant

Carer
Maureen Johnson – elected in May 2013, re-elected in April 2016.
Anthony Brookes – elected January 2015, re-elected unopposed in January 2018
Michelle Long – elected January 2015, re-elected unopposed in January 2018

Service User Birmingham
Faheem Uddin – elected October 2011, re-elected unopposed in November 2014 and October 2016
Mustak Mirza - elected unopposed in March 2017.

Service User Solihull
Peter Brown - elected unopposed March 2012, re-elected unopposed in February 2015 and re-elected in January 2018.

Service User rest of England and Wales
Michael Humes – co-opted August 2016, stepped down in March 2018.

Staff
Dr Felicia N. Orlu (Clinical medical) – elected unopposed in August 2018, stepped down in March 2018
Julie Ramsdale-Owen (Non-clinical) – elected through a contested election in October 2016
Neil Edwards (Clinical, non-medical) – elected through a contested election in October 2016, stepped down in March 2018.

Stakeholder
Michael Adams (Birmingham City University) – appointed September 2015, stepped down in September 2017, replaced by Jim Chapman.
Maureen Smojkis (University of Birmingham) – reappointed in March 2018.
Cllr Mick Brown (Birmingham City Council) – reappointed September 2016.
Joanne Fairburn (Solihull MBC), appointed July 2016, stepped down in July 2017, replaced by Cllr Alan Rebeiro.
Natalie Allen (Council for Voluntary Services) – appointed in November 2016.
Superintendent Sean Russell (West Midlands Police) – reappointed September 2016.
Dr Aqil Chaudary (NHS Birmingham and Solihull Clinical Commissioning Group) - reappointed December 2016.

Council of Governors attendance 2017/18

	May 2017	July 2017	Sept 2017	Nov 2017	Jan 2018	Mar 2018
Governor attendance						
Michael Adams	✓	✓				
Khalid Ali	✓	O	O	O	O	✓
Natalie Allen	O	O	✓	✓	✓	✓
Anthony Brookes	✓	✓	✓	✓	✓	✓
Mick Brown	✓	O	O	O	O	✓
Peter Brown	✓	✓	✓	✓	✓	✓
Jim Chapman				✓	✓	O
Aqil Chaudary	O	O	O	✓	O	O
Robert Dalziel	O	✓	✓	✓	✓	✓
Neil Edwards	✓	O	✓	✓	✓	✓
Joanne Fairburn	O					
Michael Humes	✓	O	O	O	O	
Maureen Johnson	O	✓	✓	✓	✓	✓
Phil Jones	✓	O	O	O	O	✓
Hazel Kench	✓	✓	✓	✓	✓	✓
Michelle Long	✓	O	✓	O	O	O
Mustak Mirza	✓	✓	✓	✓	✓	✓
Dr Felicia N. Orlu					✓	
Julie Ramsdale-Owen	✓	O	✓	O	✓	✓
Alan Rebeiro		✓	✓	✓	✓	O
Sean Russell	✓	O	O	O	✓	✓
Maureen Smojkis	✓	O	O	O	✓	✓
Faheem Uddin	✓	✓	✓	✓	✓	✓
Non-Executive Director attendance						
Sue Davis	✓	✓	✓	✓	✓	✓
Russell Beale	O	✓	✓	✓	✓	✓
Barry Henley	O	✓	✓	✓	O	✓
Nerys Williams	O	O	✓	✓	O	✓
Waheed Saleem	✓	✓	O	✓	✓	✓
Joy Warmington	O	✓	✓	✓	O	✓
Gianjeet Hunjan	✓	✓	✓	✓	✓	✓
Director attendance						
John Short	✓	✓	✓	✓	✓	✓
Brendan Hayes	O	✓	✓	O	✓	✓
Sue Hartley	✓	✓	O	✓	✓	✓
Hilary Grant	✓	✓	✓	✓	✓	✓
Charlotte Bailey			O	✓	O	O
Dave Tomlinson	✓	O	O	✓	✓	✓

O = did not attend ✓ = attended meeting

Key activity of governors in 2017/18

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

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

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

Actively engaging members to gather their thoughts, our governors have been out and about for the past year, attending a very wide range of carer, service user and stakeholder groups and forums, representing the Trust on a number of issues. As well as membership, governors also take a keen interest in staff engagement and staff recognition.

The Health and Social Care Act 2012 has seen a change in governor responsibilities. In keeping with this, governors attend the private Board session, have undertaken training and regularly attend conferences such as those held by NHS Providers, or by the local health economy within the West Midlands. These conferences help governors develop within their role, and also offer networking opportunities.

To further support this, governors have been given an induction pack and toolkit and have been asked to participate in a skills audit. Governors were asked to rate their knowledge, understanding and competence in a range of areas. This informed the training and development plan put in place for 2017/18.

The membership and governor support team, together with governors, have been involved in a wide variety of ways across the year.

This includes some exceptional work by governors, for example:

- the development and then championing of our recovery model and Recovery College for All
- helping to improve our investigations into serious incidents and complaints
- presenting at key events, including at universities on lived experience
- participation on behalf of the Trust in the Birmingham City Council Scrutiny Panel to assist in scrutiny investigations into the interface between mental health and the criminal justice system
- participation in regional and national governor conferences and events
- participation on recruitment panels including those for members of the Board.

Other key engagement and involvement work has included the following:

- Work with Birmingham City University and University of Birmingham to reach out to young people which is an area of under-representation in our membership.
- Work with Extra Care Housing Charitable Trust to support engagement with the over 55s which is another area of under-representation.
- Seminars on eating disorders, diabetes and mental health; improving physical and mental health wellbeing; memory loss and diabetes and dementia awareness.
- An annual members meeting attended by c120 people, which included presentations from the Lead Governor and involvement from a range of governors.
- Participation in an equality analysis workshop.
- Participation in and Research and Innovation development event.
- Attendance at a wide range of carers events.
- Attendance at the Prison Healthcare Seminar on Treatment Behind Bars.
- Attendance at our Trust Quality and Excellence Awards for staff and other staff recognition events.
- Volunteers' tea party and volunteer recruitment events.
- Participation in Sustainability and Transformation Partnership stakeholder reference group events.
- Participation in workshops to develop our new Strategic Partnerships Strategy.
- Acting as judges on our Trust Dragons' Den innovation events.
- Joint strategic sessions with the Board.
- Discussions around joint working with Birmingham Women's and Children's NHS Foundation Trust.
- Participation in our recent full CQC inspection feedback and action plans.
- Participation in dementia cafés with the Alzheimer's Society.
- Participation in events on World Mental Health Day.
- Participation in Black History Month events.
- Participation in a GP Mental Health Matters event in Solihull.

Our members

We recognise the importance of an effective membership to the successful governance of the Trust and the delivery of a good quality service.

Our aim is for our members to become active, engaged and representative of local communities, staff, and the wider population we serve.

Members should be our critical friends, having a meaningful say in decisions about how our services are planned and provided. Membership also allows local people and communities to bring their knowledge, experiences and enthusiasm to the Trust.

Current position

As at the end of March 2018, our membership stood at 12,688 overall, comprising 6,557 members of the public,1,415 service users and carers and 4,716 staff. This compares with an overall figure of 12,960 as at the end of March 2017. The Trust carried out an extensive review of the membership and contacted many of the members to update their details.

This led to a reduction in membership as a number were found to have moved away, requested removal or were deceased.

Representation

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

Analysis of current public and patient membership at 31 March 2018

Age	Public 2017	Public 2018	Service User/ Carer 2017	Service User/ Carer 2018
0-16	16	9	1	0
17-21	61	57	16	12
22+	5,558	5,412	1,213	1,199
Not stated	1,114	1,079	213	204
Total	**6,749**	**6,557**	**1,443**	**1,415**

Public and patient membership gender profile at 31 March 2018

Gender	Public 2017	Public 2018	Service User/ Carer 2017	Service User/ Carer 2018
Unspecified	117	114	24	23
Male	2,428	2,352	522	510
Female	4,204	4,091	896	881
Transgender	0	0	1	1
Total	**6,749**	**6,557**	**1,443**	**1,415**

Public and patient membership ethnicity profile at 31 March 2018

Ethnicity	Public 2017	Public 2018	Service User/ Carer 2017	Service User/ Carer 2018
White	2,742	2,636	778	759
Mixed	182	181	48	47
Asian or Asian British	1,884	1,859	361	359
Black or Black British	785	770	178	175
Other	87	85	24	24
Not stated	1,087	1,026	54	52
Total	**6,749**	**6,557**	**1,443**	**1,415**

Public member constituency socio-economic groupings at 31 March 2018

Acorn Socio-Economic Category	Public 2017	Public 2018
AB	1,583	1,543
C1	1,817	1,773
C2	1,382	1,356
DE	1,784	1,754
Not known	183	20
Total	**6,749**	**6,446**

Overall there is a good mix of ages, gender and individuals from different ethnic minorities. As is to be expected, the largest group fall under the White category but there is a good mix of Asian, Black and Mixed. There are some areas where further work is required to bring the representation up. In terms of representation of the membership, the Trust is constantly looking for opportunities to engage with its communities.

We have a well-developed programme around community engagement and equality and diversity and the work around membership has dovetailed with this which has enabled interaction with a wide range of hard to reach groups. The ethnicity classifications have changed over time and it may have been that backgrounds such as Irish traveller would have been listed under other or not stated.

We have attempted to address under-representation over the last year, particularly in relation to the 17-21 age category, through our work with Birmingham City University and University of Birmingham and under-representation in the over 60s through our work with Extra Care Housing Charitable Trust, such as running events in their retirement villages. This work will continue in 2018/19 and will be expanded to include a focus on schools and colleges of further education. The Membership and Governor Engagement Strategy will be refreshed during 2018/19 and this will include a review of the focus for the next three years.

Eligibility

Application for membership

An individual who is eligible to become a member of the Trust may do so on application to the Trust. The minimum age to become a member is 12.

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

- 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, into the following groups: public members, service user members and carer members

Public constituency

An individual who lives in the specified area specified may become or continue as a member of the Trust. Those individuals who live in an area specified as an area for any public constituency are referred to collectively as the Public Constituency.

Staff constituency

An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

- he/she is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or
- he/she has been continuously employed by the Trust under a contract of employment for at least 12 months
- individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency. The Staff Constituency shall be divided into three descriptions of individuals who are eligible for membership of the Staff Constituency.

Service user and carer constituency

An individual who has attended any of the Trust's hospitals as either a patient or as the carer of a patient may become or continue as a member of the Trust.

The Service User and Carer Constituency shall be divided into four descriptions of individuals who are eligible for membership of the Service User and Carer Constituency.

Objectives

The Council approved a Membership Engagement and Governor Involvement Strategy in 2015. In essence our mission is:

To become a leader in the field of mental health membership engagement and governor Involvement, driving forward equality for mental health service users (parity of esteem), their carers and families, reducing stigma and supporting the Trust to deliver its strategic ambitions.

By the end of three years we would want to be able to quantify improvements in:

- collation of views from the membership which has had a demonstrable impact on our forward planning as an organisation
- developing a more representative membership
- processes for governors to engage with their constituencies, including strong in-year plans which are demonstrating improved engagement reflected in our annual reports
- identifying and carrying out successful governor led campaigns including joint campaigns with partner mental health organisations in the region
- being known nationally as an exemplar organisation in mental health governor and member engagement.

The aim of the strategy is to:

- support the Council of Governors in being more proactive in its engagement and involvement

- make best use of the skills, knowledge and expertise its governors bring and to support them to engage effectively within the organisation, with patients, staff, members and the wider community
- have better connectivity and planning
- support the Trust to be an organisation viewed of as dynamic in terms of participation from members
- increase representation across the constituencies
- support the visibility of the Council both internally and externally
- improve communications with members
- improve feedback mechanisms
- enable more input from members into service design and provision
- improve patient and carer experience
- improve dialogue between health professionals and patients, and within our local health communities
- improve dialogue between the Trust and major employers in our area – exploring potential linkages into their corporate social responsibility agendas
- break down stigma around mental health and promote parity of esteem
- effectively target resources (saving time and money and improving focus) resulting in membership engagement which is genuinely meaningful.

Arrangements in place to ensure that services are well-led

We take our corporate governance responsibilities seriously and focus on service leadership as a key component of this. In doing so, we pay due regard in particular to NHS Improvement's Well-Led Framework and the Care Quality Commission's Regulations. Our approach to this is detailed in the Annual Governance Statement section of this report, including reference to:

- system of internal control
- capacity to handle risk
- risk and control framework
- review of economy, efficiency and effectiveness of the use of resources.

As important as the design of such processes and frameworks is the way they are applied, how effective they are and what the outcomes are. Other sections of this report cover financial standing, performance, quality and staff engagement and satisfaction, while examples of the work carried out this year to assess and improve the way we govern and lead include the following:

- **Self-assessment of committee effectiveness**: Each year we review the effectiveness of Board committees. During the autumn, at the instigation of the Audit Committee Chair, we strengthened the process to ensure an aligned and consistent approach across all committees. Following a review of best practice in Audit Committee assessment, we developed a methodology which combined a desk top assessment of the design of the governance system with a survey of relevant stakeholders to assess how well things operated in practice. As a result we were able to confirm that the governance system worked well, while also identifying areas for refinement and improvement. This supported our annual review of committee terms of reference.

- **Internal Audit**: In accordance with NHS Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes. This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee. During the year, we reviewed the internal audit contract and decided to appoint TIAA as successors to Deloitte. Their fresh perspective and insights allowed us to challenge the effectiveness of our existing approach.

- **Summerhill Supplies Limited (SSL)**: SSL was incorporated in 2012 as a wholly-owned subsidiary of the Trust. SSL is a specialist facilities management provider, owning and operating three major hospital sites on the Trust's behalf. SSL has delivered high quality services to the Trust, improving operational performance and flexibilities, staff morale and motivation and cost savings. During the year, we reviewed the Trust's business relationship with SSL to ensure that the decision making and development processes are effective and efficient, increasing clarity around the governance arrangements and staff relationships. We worked with Staff Side representatives to explore key issues and identify how to allay any concerns they might have, a move which was welcomed.

- **Listening, involving and improvement** – In spring 2017, the Care Quality Commission (CQC) reviewed Trust services. Their assessment that improvement was required was disappointing and caused great concern to staff and stakeholders. However, we took the assessment as a catalyst for enhancing our approach to staff engagement and quality improvement. Since then, the rating for our Solar service has been uprated from 'inadequate' to 'good' and there have been a number of other positive changes to individual ratings. One of CQC's criticisms related to the Trust's policy of searching service users and we worked closely with clinicians and other staff to work through how we could improve things. This was seen as a positive development and we intend to maintain this new involvement and engagement approach, building on our programme of listening and engagement, which includes our 'Dear John' process, 'Listen Up' conversations between executive directors and staff and visits by executive and eon-executive directors to facilities across the Trust to see things first hand. Every Board meeting begins with a service user story, where a service user tells us about their experience of services and this has proven very enlightening, keeping us attuned to how things are for the people we serve. In the autumn, we agreed to build on and enhance our quality improvement approach by launching a Trustwide development programme during the next few months to fully embed and deepen our continuous improvement approach, providing staff with the skills, training and authority to drive improvements.

- **Strategic direction**: We have strengthened our strategic planning, driven by the refreshed Trust Strategy approved in March 2017. Further enabling strategies have been developed to guide our thinking and direction, primarily in the areas of quality, workforce, information, estates, partnerships, business development, communications and marketing. We have improved the transparency of our financial reporting, with a reduction in the use of technical jargon, and worked closely with our service leaders to develop clear service strategies and plans. This has been bolstered by development of our long term financial and capital planning processes.

During the autumn we carried out a programme of directorate planning reviews, with executive directors working with service and corporate management teams to explore their long term ambitions and define what success looks like. This has developed in the first few months of 2018 with the introduction of a programme of Service Area Support and Review meetings and the continuation of quarterly presentations by service area leads to the Finance, Performance and Productivity Committee. This all helps evidence our commitment to a philosophy of listening, involvement and engagement.

- **Board Assurance Framework and risk management**: One of CQC's criticisms related to the Trust's approach to risk management and assurance. We have critically reviewed the way that we manage risk and enhanced both the Board Assurance Framework and the Risk Management Policy, improving the quality and transparency of reporting and making it more readily understandable. These improvements will continue in the months to come, as we build our review and management of risks into the development of integrated performance reporting, allowing us to take a holistic and balanced approach to the management of performance and assurance.

- **Information Governance:** We have spent much of the year considering how best to respond to the introduction of the General Data Protection Regulations (GDPR) in May 2018, when they supersede the UK Data Protection Act 1998 (DPA). The new law is significant and wide-reaching, expanding the rights of individuals to control how their personal data is collected and processed, and placing new obligations on organisations to be more accountable for data protection. Given our involvement in and commitment to partnership working with other organisations, we have had to develop a robust approach to information sharing in order to strike the right balance between safeguarding patient confidentiality and using information to ensure joined up working and care. During the year we reviewed our information governance framework and the Information Governance Steering Group now reports directly to the Integrated Quality Committee. In addition, we have taken steps to build critical mass and resilience into our information governance functions and appointed a Data Protection Officer, an appointment mandated by GDPR which must be independent, an expert in data protection, adequately resourced, and report to the highest management level.

- **Information Communications and Technology (ICT)**: In the spring of 2017, the Trust was successful in its bid to become one of seven mental health trusts and 23 trusts in total to be awarded global digital exemplar status. As per NHS England, 'A Global Digital Exemplar is an internationally recognised NHS provider delivering exceptional care, efficiently, through the use of world-class digital technology and information'. The ICT department led a number of important developments over the year, including the migration to NHS Mail. This was a difficult and trying piece of work, but the department performed above and beyond throughout the period to ensure we were able to function effectively, evidenced by positive feedback from a Trustwide survey of staff. We are seeking to improve the way that we use technology, introducing observation apps for the wards (which have been warmly welcomed) and single sign on, which means that staff do not have to remember multiple passwords to access Trust systems.

Following staff comment about the speed, responsiveness and fitness for purpose of systems and technological infrastructure, we have introduced regular updates to the Finance, Performance and Productivity Committee to improve the robustness of oversight and assurance.

- **Response to NHS cyber-attack and Grenfell disaster**: The NHS, like all public sector organisations, needs to respond proactively to issues such as this. It can often feel like having to 'tick the box' for shortcomings elsewhere in the country, which can be very frustrating, but we were delighted to see our arrangements for both fire safety and cyber security confirmed as being excellent as we were able to respond strongly to requests for information and assurance. We take a very proactive approach to such things and are regarded as one of the best Trusts in the country in terms of cyber-resilience.

The Trust confirms that it does not believe there to be any inconsistencies between the reporting provided throughout the annual report and returns provided to NHS Improvement or with reviews received from the CQC.

Patient care

The following areas are covered in the quality report which is part of this annual report.

- Service user and carer experience and involvement.
- Arrangements for monitoring improvements in the quality of healthcare and progress towards meeting any national and local targets, incorporating Care Quality Commission assessments and reviews and the NHS foundation trust's response to any recommendations made.
- Progress towards targets as agreed with local commissioners, together with details of other key quality improvements.
- Improvements in quality of care.
- Information on complaints and PALS.

Stakeholder relations

Details of significant partnership and alliances, development of services with other local services/agencies and involvement in local initiatives are described in the performance report section of this annual report.

Consultation with local groups and organisations

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.

Statement as disclosure to auditors

The Trust has specifically asked each director to confirm that in so far as they are aware there is no relevant audit information of which the auditor is unaware. Each has confirmed that they have taken all steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

Statement on the Annual Report and Accounts

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

Remuneration report

Annual statement on remuneration and senior managers' remuneration policy

Key areas discussed by the Remuneration Committee in the financial year, in respect of remuneration were as follows:

- Annual report on retire and return applications and those which were agreed.
- Executive Director and Company Secretary objectives.
- A one percent pay increase to those Executive Directors employed on 31 March 2017 to be applied with effect from 1 April 2017.
- A report on the use of Lay Managers within the Trust.
- The Committee received a report on options available for the development of Executive Pay Framework.
- The Committee agreed proposals for consultation on the change of Executive Pay Framework.

No new components of the remuneration package for senior managers have been introduced.

The Trust does not have a senior managers' remuneration policy in place. The following table outlines the policy going forward and reflects current practice.

There is a policy in place for overpayments for all staff, including senior managers, agreed with the payroll provider.

Future Policy Table

Element	Purpose and link to strategic objectives	Operation
Base salary and pension related benefits	Directors' individual performance objectives reflect the Trust's organisational objectives and strategic ambitions. Base salaries have been set by the Trust's Remuneration Committee, taking account of the relevant size of the job roles and median salary levels of comparable roles in other NHS organisations. Performance against agreed objectives is reviewed by the Chief Executive/Chair with outcomes reported to the Remuneration Committee.	These are spot salaries set within an agreed pay band. There is no performance related pay element, and pay elements are neither awarded or withheld pending performance assessment. Annual salary levels are subject to application of cost of living pay award determined by the Remuneration Committee. Pay bands reflect the seniority of roles at executive director level and provide appointment panels with scope to appoint new staff from within the pay band. Pay bands do not include incremental progression (increments apply for staff employed under Agenda for Change: bands 1-9, and doctors) Executive directors are members of the NHS Pension Scheme. No senior managers have rights under more than one type of pension within Birmingham and Solihull Mental Health NHS Foundation Trust.
Additional payments (Executive Director of Operations only)	To act as deputy for the Chief Executive in his absence.	The Chief Operating Officer receives an additional £5K per year (introduced in 2013).
Chair and non-executive directors fees	Trust Board determines the strategic objectives for the organisation; objectives are put in place for NEDs to reflect these	Remuneration for the Chair and the NEDs is determined by the Nominations and Remuneration Committee and approved by the Council of Governors. There is no performance related pay element; remuneration levels have been benchmarked with similar sized foundation trusts.

Base salaries are paid within an agreed pay band. The maximum that can be paid is the top of the pay band.

As at 1 April 2017, salaries for non-executive directors were

Chair	£46k
Vice Chair	£20k
Other non-executive directors	£15k

Non-executive directors do not receive any additional fees for any other duties. As stated salaries are not dependent upon performance, in terms of recovery the following paragraphs are included in the contract:

The Trust will be entitled to deduct regularly from your salary any amounts properly owed to the Trust including but not limited to residential accommodation, trade union dues, meals, beverages, telephone charges, nursery fees, library fees and car loan charges as appropriate.

Should you terminate your contract with the Trust then any outstanding charges will be deducted from your final salary payment. When large amounts are outstanding discussion will take place with you regarding methods of payment.

With regard to the requirement to outline payments to those senior managers earning above the threshold of £142,500 if this is based on salary alone this would only apply to the Chief Executive and Executive Medical Director.

The Chief Executive's salary was benchmarked, on appointment, against other similar sized organisation.

Executive Director salaries are generally paid in the lower quartile in comparison to similar sized trusts.

Service contracts obligations

There is no obligation on the foundation trust which:

- is contained in all senior managers' service contracts;
- is contained in the service contracts of any one or more existing senior managers (not including any obligations in the preceding disclosure); and/or
- the foundation trust proposes would be contained in senior managers' service contracts to be entered into and which could give rise to, or impact on, remuneration payments or payments for loss of office but which is not disclosed elsewhere in the remuneration report.

The Trust Board decided at its December 2014 meeting that the fit and proper persons test would only be applied to executive and non-executive directors on the Trust Board. All members of the Board have declared their compliance with this and contracts have been updated to reflect the requirements of the test.

The Duty of Candour applies to all staff and information leaflets have been shared with staff reminding them of their obligations.

The Declarations Policy was updated during the year to include further requirements around declarations of Category 2 and fee paying work and with regard to a requirement to declare relationships with pharmaceutical companies. Staff at band 8c or equivalent and above are required to provide their declarations to the company secretary, with declarations for staff between band 7 and 8b to be held locally.

The request for declarations went to those at 8c and above in February 2018, with over 200 staff members approached plus Board members. At the time of writing less than 20 remained outstanding and these are being formally pursued for reporting to the Audit Committee. Counter Fraud services supported the Trust in developing the Declarations Policy and Pay Policy.

Executive director posts are substantive appointments with no set period of employment or end date. Notice periods are detailed in the next section below.

Non-executive directors do not have a notice period as they undertake fixed terms of office and are subject to re-appointment.

Policy on payment for loss of office

Executive directors are entitled to three months' notice of termination of employment, consistent with contracts for all other senior staff employed by the Trust, except for the Chief Executive, who is entitled to six months' notice.

Where loss of office (dismissal) occurs, payments will be paid in accordance with the senior manager's contract, including notice and contractual redundancy pay (if applicable).

The circumstances of the loss of office and the senior manager's performance are not relevant to any exercise of discretion.

Consideration of employment conditions elsewhere in the foundation trust

The terms and conditions of employment for senior managers largely reflect the terms applicable for other staff, except in the case of annual leave entitlements (35 days, as opposed to a maximum for other staff of 33 days). Pay bands for senior managers exceed the maximum pay band (band 9) for other senior staff employed under Agenda for Change. Senior managers are subject to the national cap on redundancy payments.

We did not consult with employees when preparing the senior managers' remuneration policy. The pay bands for senior managers were determined by reference to comparable sized job roles in similar NHS organisations.

Annual report on remuneration

Information not subject to audit

Appointments and tenures of non-executive directors

Appointments and tenures of non-executive directors

Name	First Appointed	Current Term
Sue Davis	28 November 2011	1 December 2017 – 1 December 2020
Nerys Williams	1 December 2011	1 December 2014 - 1 December 2018 (term originally ended on 1 December 2017 and was extended for one year)
Joy Warmington	3 January 2012 (Associate Non-Executive Director) 1 May 2013 (Non-Executive Director)	1 May 2016 – 1 May 2019
Waheed Saleem	1 July 2013 (Associate Non-Executive Director) 1 August 2015 (Non-Executive Director)	1 July 2016 – 1 July 2019
Barry Henley	1 July 2013	2 July 2016 – 1 July 2019
Gianjeet Hunjan	1 September 2015 (Associate Non-Executive Director) 1 September 2016 (Non-Executive Director)	1 September 2016 – 1 September 2019
Russell Beale	1 January 2017	1 January 2017 – 1 January 2020

The terms and conditions for non-executive directors do not state a specified notice period. The terms of office of the non-executive directors may be terminated in accordance with their terms of engagement, which may relate to their competence, conduct or other statutory reasons. The Council of Governors at their meeting in January 2017 agreed the circumstances in which consideration would be given to a potential request for a third term of office. They agreed this should be in exceptional circumstances, would need to be as a result of an enhanced review process, and any appointment for a third term should be subject to a further review at the end of the two year point after re-appointment.

Nominations and Remuneration Committee

This Committee of the Council of Governors reviews the performance and remuneration of the Chair and non-executive directors and makes recommendations on these to the full Council.

In May 2017 the Committee discussed the outcome of the appraisal of Barry Henley and the proposed objectives for the Chair. These were approved by the Council of Governors.

In September 2017, the Committee received the outcome of appraisals for Gianjeet Hunjan, Waheed Saleem, Joy Warmington and Barry Henley and were informed that they were performing well in their roles. In regards to Nerys Williams the Committee agreed an extension of 12 months should be offered. These were approved by the governors.

The Committee received and approved a pay proposal for Non-Executive Directors for a pay uplift of one per cent for the Chair and Non-Executives, backdated to 1 April 2017 and it was confirmed pay would be reviewed annually.

In January 2018, the Committee received the outcome of the appraisal for non-executive director Russell Beale and were informed that he was performing well. The Committee agreed to the next 12 months and to the six month review.

In March 2018, the Committee received the outcome of the appraisal of the Chair, Sue Davis and were informed that she was performing well.

Membership and attendance of Nominations and Remuneration Committee 2017/18

	11/05/2017	**14/09/2017**	**11/01/2018**	**15/03/2018**
Faheem Uddin (Lead Governor)	✓	✓	✓	✓
Maureen Johnson	O	✓	✓	✓
Maureen Smojkis	✓	O	✓	✓
Hazel Kench	✓	✓	✓	✓
Neil Edwards (	✓	✓	✓	✓

O = apologies given ✓ = attended meeting P= partial

The Company Secretary and Head of Legal Services has provided advice and service to the Committee. No external advice has been received by the Committee.

The gross pay in 2017/18 for the Chair and non-executive directors is shown in the remuneration table within this report.

Remuneration Committee

The Remuneration Committee, which considers the pay and conditions of executive directors, met five times in 2017/18.

Remuneration Committee meetings, membership and attendance 2017/18

	31/05/2017	28/06/2017	26/07/2017	31/01/2018	28/02/2018
Sue Davis	✓	✓	✓	✓	✓
Nerys Williams	✓	✓	✓	✓	✓
Joy Warmington	✓	✓	O	O	✓
Barry Henley	O	✓	✓	✓	✓
Waheed Saleem	✓	✓	✓	✓	✓
Gianjeet Hunjan	✓	✓	✓	✓	✓
Russell Beale	✓	✓	✓	✓	✓

O = apologies given ✓ = attended meeting P= partial

Advice was received at some of the remuneration committee meetings by the Chief Executive, Company Secretary, and the Deputy Director of HR.

The Trust has not released any executive director to serve as a non-executive director elsewhere.

Trust Board and Governor expenses

Executive director expenses 2017/18

Executive Directors		Apr £	May £	Jun £	Jul £	Aug £	Sep £	Oct £	Nov £	Dec £	Jan £	Feb £	Mar £	Total £
Short	J	-	-	-	-	-	-	-	-	-	-	-	-	-
Hayes	B	-	32	21	-	13	-	45	32	24	-	-	89	256
Bailey	C	-	-	-	-	-	-	-	-	168	359	77	54	657
Grant	H	72	72	72	72	72	72	72	72	72	72	72	72	859
Hartley	S	-	160	-	-	-	-	-	-	370	-	132	-	662
Tomlinson	D	-	21	1,861	911	925	915	-	552	133	16	49	30	5,412
Total		**72**	**285**	**1,954**	**982**	**1,010**	**987**	**116**	**656**	**766**	**447**	**329**	**244**	**7,847**

Non-executive director expenses 2017/18

Non-Executive Directors		Apr £	May £	Jun £	Jul £	Aug £	Sep £	Oct £	Nov £	Dec £	Jan £	Feb £	Mar £	Total £
Davis	S	-	129	71	135	126	-	123	-	138	58	68	56	904
Beale	R	-	-	-	-	-	-	-	-	-	-	-	-	-
Williams	N	-	-	94	-	-	-	118	-	-	80	-	69	360
Warmington	J	-	-	-	-	-	-	-	-	-	-	-	-	-
Henley	B	-	-	-	-	-	-	-	-	-	-	-	-	-
Saleem	W	-	-	-	-	-	-	-	-	564	-	-	-	564
Hunjan	G	-	-	-	-	-	-	-	-	-	-	-	-	-
Total		**-**	**129**	**165**	**135**	**126**	**-**	**241**	**-**	**703**	**137**	**68**	**125**	**1,829**

Governor expenses 2017/18

Governors		Apr £	May £	Jun £	Jul £	Aug £	Sep £	Oct £	Nov £	Dec £	Jan £	Feb £	Mar £	Total £
Chaudary	A	-	-	-	-	-	-	-	-	-	-	-	-	-
Uddin	F	-	-	-	-	-	-	-	-	-	-	-	-	-
Ali	K	-	-	-	-	-	-	-	-	-	-	-	-	-
Brookes	A	-	-	-	-	-	-	-	-	-	-	-	-	-
Long	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Jones	P	-	-	-	-	-	-	-	-	-	-	-	-	-
Johnson	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Smojkis	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Brown	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Russell	S	-	-	-	-	-	-	-	-	-	-	-	-	-
Kench	H	-	-	-	-	-	-	-	-	96	-	-	-	96
Dalziel	R	-	-	-	-	-	-	-	-	-	-	-	-	-
Edwards	N	-	-	-	-	-	-	-	149	86	21	-	-	256
Fairburn	J	-	-	-	-	-	-	-	-	-	-	-	-	-
Adams	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Humes	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Mirza	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Allen	N	-	-	-	220	-	-	-	-	-	-	-	-	220
Brown	P	-	-	-	-	-	-	-	-	-	-	-	-	-
Ramsdale-Owen	J	64	-	-	-	97	-	26	-	-	-	-	82	269
Total		**64**			**220**	**97**		**26**	**149**	**182**	**21**	**-**	**82**	**841**

Governor Election Expenses were £1,594 during the year.

Executive director expenses 2016/17

Executive Directors		Apr £	May £	Jun £	Jul £	Aug £	Sep £	Oct £	Nov £	Dec £	Jan £	Feb £	Mar £	Total £
Short	J	-	-	-	-	-	-	-	-	-	-	-	-	-
Hayes	B	54	33	-	67	-	-	74	-	-	97	-	25	351
Betney	S	42	-	93	-	-	119	-	-	-	135	132	8	529
Grant	H	-	-	-	72	72	72	72	72	72	72	72	72	644
Hartley	S	-	-	-	170	55	-	-	-	-	127	-	-	352
Total		**96**	**33**	**93**	**309**	**127**	**190**	**146**	**72**	**72**	**431**	**203**	**104**	**1,876**

Non-executive director expenses 2016/17

Non-Executive Directors		Apr £	May £	Jun £	Jul £	Aug £	Sep £	Oct £	Nov £	Dec £	Jan £	Feb £	Mar £	Total £
Davis	S	-	206	468	-	176	65	86	48	-	-	155	77	1,280
Beale	R	-	-	-	-	-	-	-	-	-	-	-	-	-
Heer	S	-	-	-	-	-	-	-	-	-	-	-	-	-
Williams	N	282	500	-	-	-	-	143	-	187	-	-	252	1,363
Warmington	J	-	-	-	-	-	-	-	-	-	-	-	-	-
Henley	B	-	-	-	-	-	-	-	-	-	-	-	-	-
Saleem	W	44	-	-	245	-	-	-	-	-	-	-	291	580
Hunjan	G	-	-	-	-	-	-	-	-	-	-	-	-	-
Total		**326**	**706**	**468**	**245**	**176**	**65**	**229**	**48**	**187**	**-**	**155**	**619**	**3,224**

Governor expenses 2016/17

Governors		Apr £	May £	Jun £	Jul £	Aug £	Sep £	Oct £	Nov £	Dec £	Jan £	Feb £	Mar £	Total £
Chaudary	A	-	-	-	-	-	-	-	-	-	-	-	-	-
Uddin	F	-	-	-	-	-	-	-	-	-	-	-	-	-
Ali	K	-	-	-	-	-	-	-	-	-	-	-	-	-
Brookes	A	-	-	-	-	-	-	-	-	-	-	-	-	-
Long	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Jones	P	-	-	-	-	-	-	-	-	-	-	-	-	-
Johnson	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Smojkis	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Brown	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Russell	S	-	-	-	-	-	-	-	-	-	-	-	-	-
Kench	H	-	-	-	-	-	-	-	-	-	-	-	164	164
Dalziel	R	-	-	-	-	-	-	-	-	-	-	-	-	-
Edwards	N	-	-	-	-	-	-	-	-	-	-	-	-	-
Fairburn	J	-	-	-	-	-	-	-	-	-	-	-	-	-
Adams	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Humes	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Mirza	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Allen	N	-	-	-	-	-	-	-	-	-	-	-	-	-
Brown	P	-	-	-	-	-	-	-	-	-	-	-	-	-
Wilde	K	-	-	-	-	-	-	-	-	-	-	-	-	-
Maxfield	S	-	-	-	-	-	-	-	-	-	-	-	-	-
Cullen	P	-	-	-	-	-	-	-	-	-	-	-	-	-
Okill	L	-	-	-	-	-	-	-	-	-	-	-	-	-

Governors		Apr £	May £	Jun £	Jul £	Aug £	Sep £	Oct £	Nov £	Dec £	Jan £	Feb £	Mar £	Total £
Khan	A	-	-	-	-	-	-	-	-	-	-	-	-	-
Griffiths	T	-	-	-	-	-	-	-	-	-	-	-	-	-
Ramsdale-Owen	J	-	-	-	-	-	-	-	-	-	-	-	-	-
Total		**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**164**	**164**

Governor Election Expenses were £3,513 during the year.

Information subject to audit

Remuneration table

Salary and pension entitlements of senior managers – salaries and allowances

Name and Title	Year Ending 31 March 2018					Year ending 31 March 2017				
	Salary	Other remuneration	Benefits in kind	Pension - Related Benefits	Total	Salary	Other remuneration	Benefits in kind	Pension - Related Benefits	Total
	(Bands of £5,000)	(Bands of £5,000)	(rounded to nearest £100)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £5,000)	(rounded to nearest £100)	(Bands of £2,500)	(Bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
John Short (Chief Executive Officer – Appointed 1 April 2013)	*165-170*	-	-	32.5-35	200-205	*165-170*	-	-	37.5-40	200-205
Sandra Betney (Executive Director of Resources – Appointed 1 February 2013)						*120-125*	-	-	-	120-125
Hilary Grant (Executive Medical Director - Appointed 1 April 2017)	95-100	55-60	-	62.5-65	220-225	95-100	55-60	-	195-197.5	350-355
Brendan Hayes (Chief Operating Officer/ Deputy CEO – Appointed 15 July 2013)	115-120	-	-	250-252.5	365-370	115-120	-	-	-	115-120
Susan Hartley (Executive Director of Nursing – Appointed 31 March 2014)	110-115	-	-	15-17.5	125-130	105-110	-	-	55-57.5	165-170

Name and Title	Year Ending 31 March 2018					Year ending 31 March 2017				
	Salary	Other remuneration	Benefits in kind	Pension - Related Benefits	Total	Salary	Other remuneration	Benefits in kind	Pension - Related Benefits	Total
	(Bands of £5,000)	(Bands of £5,000)	(rounded to nearest £100)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £5,000)	(rounded to nearest £100)	(Bands of £2,500)	(Bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Dave Tomlinson (Executive Director of Finance – Appointed 1 April 2017)	115-120	-	-	-	115-120					
Charlotte Bailey (Executive Director of Strategic Partnerships – Appointed 1 August 2017)	70-75	-	-	15-17.5	90-95					
Sue Davis (Chair – Appointed 28 November 2011)	45-50	-	-	-	45-50	45-50	-	-	-	45-50
Sukhbinder Heer (Non-Executive Director - Appointed 13 August 2007, resigned 30 April 2016)						0-5	-	-	-	0-5
Nerys Williams (Non-Executive Director – Appointed 1 December 2011)	15-20	-	-	-	15-20	15-20	-	-	-	15-20
Joy Warmington (Non-Executive Director – Appointed 3 January 2012)	20-25	-	-	-	20-25	15-20	-	-	-	15-20
Waheed Saleem (Non-Executive Director – Appointed 1 July 2013)	15-20	-	-	-	15-20	15-20	-	-	-	15-20

Name and Title	Year Ending 31 March 2018					Year ending 31 March 2017				
	Salary	Other remuneration	Benefits in kind	Pension - Related Benefits	Total	Salary	Other remuneration	Benefits in kind	Pension - Related Benefits	Total
	(Bands of £5,000)	(Bands of £5,000)	(rounded to nearest £100)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £5,000)	(rounded to nearest £100)	(Bands of £2,500)	(Bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Dr Barry Henley (Non-Executive Director – Appointed 1 July 2013)	15-20	-	-	-	15-20	15-20	-	-	-	15-20
Prof Russell Beale (Non-Executive Director) (Appointed 1 January 2017)	15-20	-	-	-	15-20	0-5	-	-	-	0-5
Gianjeet Hunjan (Non-Executive Director – Appointed 1 September 2015)	15-20	-	-	-	15-20	10-15	-	-	-	10-15
For both 2017/18 and 2016/17 there were no annual performance related bonuses or long term performance related bonuses. The Medical Director was paid £58k during the year ended 31 March 2018 (£60k during year ended 31 March 2017) for non-director responsibilities.										

Fair pay multiple

Fair pay multiple

	2017/18	2016/17
Band of Highest Paid Directors Total Remuneration (£'000)	165-170	165-170
Median Total Remuneration	28,043	26,302
Ratio	5.98	6.32

Median pay-method of calculation: *the payroll data was examined, exceptional items that would distort the calculation were excluded, the normalised data was used to derive an annualised pay figure, and the median calculation was determined from the resultant data set.*

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid director in Birmingham and Solihull Mental Health NHS Foundation Trust in the financial year 2017/18 was £165-170k (2016/17, £165-170k). This was 5.98 times (2015/16 6.32 times) the median remuneration of the workforce, which was £28k (2015/16, £26k). In 2017/18, five employees received remuneration in excess of the highest paid director (in 2016/17 the figure was five). Remuneration ranged from £169k to £215k (2016/17 £167 to 193k).

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

Pension entitlements

Pension benefits 2017/18

Name and Title	Real Increase In Pension at Age 60	Lump Sum at Age 60 Related To Real Increase In Pension	Total Accrued Pension at Age 60 Ending 31 March 2018	Lump Sum at Age 60 Related To Accrued Pension at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2018	Real increase in accrued pension during year
	(Bands of £2,500) £'000	(Bands of (£2,500) £'000	(Bands of £5,000) £'000	(Bands of £5,000) £'000	£'000	£'000	£'000
John Short (Chief Executive Officer)	2.5-5	7.5-10	65-70	195-200	1,297	1,401	91
Charlotte Bailey (Executive Director of Strategic Partnerships)	0-2.5	0	0-5	0	0	12	8
Dave Tomlinson (Executive Director of Finance)	0	0	0	0	0	0	0
Hilary Grant (Executive Medical Director) (Appointed 1 April 2016)	2.5-5	10-12.5	50-55	160-165	1,028	1,175	136
Brendan Hayes (Chief Operating Officer / Deputy CEO)	10-12.5	35-37.5	45-50	140-150	634	904	264
Susan Hartley (Executive Director of Nursing)	0-2.5	2.5-5	40-45	120-125	734	812	70

Pension benefits 2016/17

Name and Title	Real Increase In Pension at Age 60	Lump Sum at Age 60 Related To Real Increase In Pension	Total Accrued Pension at Age 60 Ending 31 March 2017	Lump Sum at Age 60 Related To Accrued Pension at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2016	Cash Equivalent Transfer Value at 31 March 2017	Real increase in accrued pension during year
	(Bands of £2,500) £'000	(Bands of (£2,500) £'000	(Bands of £5,000) £'000	(Bands of £5,000) £'000	£'000	£'000	£'000
John Short (Chief Executive Officer)	2.5-5	7.5-10	60-65	185-190	1,175	1,297	122
Sandra Betney (Executive Director of Resources)	0-2.5	0-2.5	34-40	105-110	590	618	28
Hilary Grant (Executive Medical Director) (Appointed 1 April 2016)	7.5-10	27.5-30	50-55	150-155	813	1,028	216
Brendan Hayes (Chief Operating Officer / Deputy CEO)	0-2.5	0-2.5	30-35	100-105	604	634	30
Susan Hartley (Executive Director of Nursing)	2.5-5	7.5-10	35-40	115-120	657	734	77

There is no additional benefit that will become receivable by a director in the event that that senior manager retires early.

No senior managers have rights under more than one type of pension within Birmingham and Solihull Mental Health NHS Foundation Trust.

Payments for loss of office

There have been no payments made for loss of office in the reporting period.

Payments to past senior managers

There have been no payments to past senior managers in the reporting period.

Signed:

John Short, Chief Executive
Birmingham and Solihull Mental Health NHS Foundation Trust Date: 23 May 2018

Staff report

Our staff are our greatest and most important asset and in the following pages we have described the actions we have taken in 2017/18 to ensure that staff are engaged and treated with fairness, dignity and respect. In this section we also describe our approach and progress during the year in relation to staff health, wellbeing and safety.

At its Trust Board meeting in March 2017, the Trust agreed a three year People Strategy and associated People Plan, which was designed to stabilise then develop areas of good practice, and introduce initiatives to support the people management agenda in the organisation. The plan is split into six sections, covering 'World Class Culture', 'Sustained Resourcing', 'Management Practice', 'Capable Workforce', 'Healthy Staff' and 'Included and Valued Colleagues'. Some of the main achievements during the year have been the success in agency reduction, from c£9m in 2016/17 to c£5m in 2017/18, a reduction in turnover, from a high of c17 per cent in January 2017 to under 13.5 per cent and implementation of Aston OD team effectiveness schemes, health and wellbeing initiatives, a reviewed equality, diversity and inclusion delivery plan and integrated workforce planning at a system, trust and directorate level. The focus for 2018/19 will be on continuing to address inequalities felt by our staff, increase the effectiveness of our teams, reduce violence towards our staff and reduce bullying and harassment.

Analysis of staff costs

Analysis of staff costs

Staff costs	**Permanent £000**	**Other £000**	**2017/18 total £000**	**2016/17 total £000**	**2015/16 total £000**
Salaries and wages	134,586	561	135,148	165,720	136,591
Social security costs	13,663	-	13,663	13,322	11,035
Apprenticeship levy	642	-	642	-	-
Employer's contributions to NHS pensions	15,783	-	15,783	15,908	16,421
Pension cost – other	-	-	-	-	-
Other post employment benefits	-	-	-	-	-
Other employment benefits	-	-	-	-	-
Termination benefits	302	-	302	188	633
Agency/contract staff	-	5,773	5,773	9,224	12,365
NHS charitable funds staff	-	-	-	-	-
Total gross staff costs	**164.977**	**6,334**	**171,311**	**174,362**	**177,045**
Recoveries in respect of seconded staff	-	-	-	-	-
Total staff costs	**164.977**	**6,334**	**171,311**	**174,362**	**177,045**
Of which Costs capitalised as part of assets	-	-	-	-	-

Average staff numbers

Average number of employees (WTE basis)

	Permanent Number	Other Number	2017/18 total Number	2016/17 total Number	2015/16 total Number
Medical and dental	126	91	217	219	257
257Ambulance staff	-	-	-	-	-
Administration and estates	732	62	794	744	811
Healthcare assistants and other support staff	660	3	663	719	716
Nursing, midwifery and health visiting staff	1,153	27	1,180	1,204	1,310
Nursing, midwifery and health visiting learners	-	-	-	-	-
Scientific, therapeutic and technical staff	505	118	623	598	666
Healthcare science staff	-	-	-	-	-
Social care staff	-	-	-	-	-
Agency and contract staff	-	-	-	-	-
Bank staff	-	-	-	-	-
Other	104	11	115	84	79
Total average numbers	**3,280**	**312**	**3,592**	**3,568**	**3,839**
Of which Number of employees (WTE) engaged on capital projects	-	-	-	-	-

Staff type by gender as at 31 March 2018

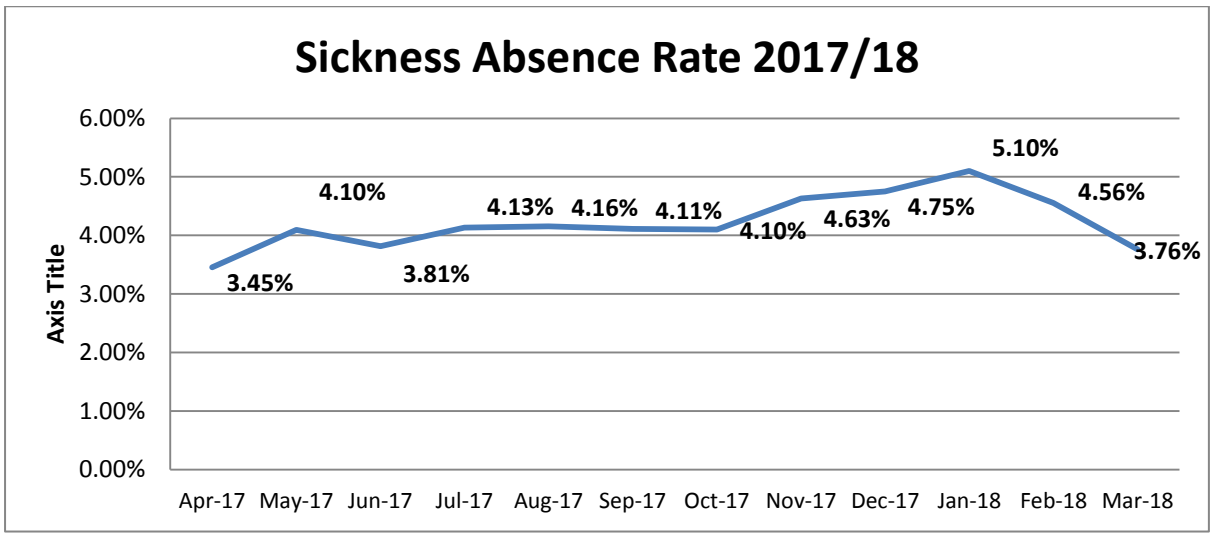
Staff type by gender at 31 March 2018

Staff Type	Female	% Female	Male	% Male	Grand Total
Directors	7	54	6	46	13
Other Senior Managers	167	61	107	39	274
Employees	2,571	71	1,029	29	3600
Total	**2,745**	**71**	**1,142**	**29**	**3,887**

Sickness absence 2017/18

Sickness absence by month 2017/18

Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
3.45%	4.10%	3.81%	4.13%	4.16%	4.11%	4.10%	4.63%	4.75%	5.10%	4.56%	3.76%



Average sick days per WTE for calendar year January 2017 to December 2017

Average WTE 2017	Adjusted WTE days lost	Average sick days per WTE
3,643	37,363	10.3

Average annual sick days per WTE has been estimated by dividing the estimated number of FTE-days sick by the average FTE and multiplying by 225 (the typical number of working days per year)

Employment and training of disabled persons

We operate the 'Disability Confident' scheme in our recruitment processes. We are committed to employing disabled people and that we will guarantee an interview if an applicant declares a disability and meets the essential criteria for a post. During the selection process we will make necessary reasonable adjustments to ensure that a disabled candidate can participate fairly and equitably in the process. If appointed, and following occupational health assessment, we will aim to make any reasonable adjustments required for the role to be successfully undertaken.

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

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

In 2017/18 we have reviewed our sickness absence policy to strengthen the support provided to disabled staff and those suffering with underlying health conditions protected under the Equality Act. These staff members now benefit from being able to take an additional five days' paid leave throughout the year for self-care at the discretion of their line manager, to prevent their condition from deteriorating.

We have introduced a portable reasonable adjustments passport which staff can take to different roles within the Trust to ensure their support requirements are maintained. In addition the Trust has signed up to the Trade Union Congress national 'Dying to Work' campaign, which supports staff with life limiting illnesses who want to remain in employment to be able to do so.

The Human Resources team meets with the Disability and Neurodiversity Network on a regular basis to see what other support we can provide to staff to support them in remaining in employment.

Disability Confident Employer

The Disability Confident scheme aims to help organisations to successfully employ and retain disabled people and those with health conditions. Being disability confident is a unique opportunity to overcome stigma and lead the way in the community.

The Trust has made a pledge to:

- get the right people for the business
- keep and develop existing staff.

We attained level 2, the Disability Confident Employer in February 2017 and are currently working on attaining level 3, Disability Confident Leader.

Staff Networks

We are committed to realising the potential of all of our staff as their personal experiences can contribute to improving service user care. We are therefore fully supportive of the staff networks we have in the Trust which are one of the means to achieve this.

Disability and Neurodiversity Staff Network

The network is pro-active and ensures staff with disabilities or impairments are represented equitably. Dave Tomlinson, our Executive Director of Finance, is the group's executive sponsor.

The network is about sharing best practice and the empowerment of staff members, supporting non-disabled staff and managers by raising awareness of issues relating to disability, ensuring that the trust benefits from disabled employees' experience and changes policy and practice as a result. It acts as a consultative group when looking to improve accessibility and as a resource for disabled staff to express their views and concerns.

In March 2018 colleagues were invited to a refreshed disability equality forum with the emphasis on supporting the network and making steady progress on disability equality.

The forum focused on two areas of work:

- The Workforce Disability Equality Standard (WDES).
- The Disability Confident Scheme.

The forum encouraged staff with lived experience of a disability or long term health condition alongside colleagues who have an interest in influencing the actions to join in and support his work going forward.

BAME Staff Network

BAME is a term used to describe a person from a visible ethnic minority and is used by a number of public bodies. We use the term to include all people who are not White British and therefore include those who are of Irish or Eastern European ethnicity.

Documented research has shown that BAME staff in the NHS face greater barriers in attaining promotion, education and professional development. The network consists of staff from multidisciplinary backgrounds across the Trust and is an open and non-formal forum. The Trust is committed to tackling inequalities in the workplace wherever we find them and Brendan Hayes, Chief Operating Officer and Deputy Chief Executive, is the executive sponsor for this network.

LGBT+ Staff Network

The LGBT+ network is a well-established and active staff network that works towards realising and developing equality for lesbian, gay, bisexual and transgender (LGBT) staff within the Trust and its associated patients, partners and stakeholders. All LGBT+ staff and allies who have an interest in improving LGBT+ equality for staff, service users and carers are welcome to join.

To mark LGBT+ History Month in February 2018, staff, service users, carers and stakeholders were invited to a fun, informative afternoon as the Trust's new Trans Equality Policy for Employees was launched. The celebration was based around the exciting show 'You've Changed' by groundbreaking theatre group Trans Creative and was led by acclaimed performance Kate O'Donnell.

Equality, diversity and inclusion is at the heart of everything we do

The government's equality strategy 'Building a fairer Britain' is underpinned by the two principles of equal treatment and equal opportunity.

By working towards the elimination of prejudice and discrimination, we can deliver services that are personal, fair and diverse and a society that is healthier and happier. This means making the Trust more accountable to the community it serves and tackling discrimination in the work place.

We have a legacy of commitment to equality, diversity and inclusion that involves and consults with the multi-cultured population it serves and the staff it employs.

The Widening Participation Team also contributes to making sure the Trust is attracting people from a range of backgrounds to pursue a career in the organisation. As a major employer, it is recognised that the NHS has the potential to make a big impact on employment and economic stability for communities and has a corporate social responsibility to do so.

We are committed to ensuring that equality and diversity is at the heart of all we do. This means ensuring that equality and fairness is embedded in the delivery of services to our service users and local community. It also means ensuring our employment practices are fair, flexible and enabling so each member of staff can reach their full potential. As required by the Public Sector Equality Duties, our annual equality monitoring report for January to December 2017 is published on the Trust website.

Staff engagement

Our ProActive Partnership staff engagement approach builds and complements staff engagement and associated delivery mechanisms that are already well established within the Trust. In 2017/18 these mechanisms have provided employees systematically with information of concern to them as employees and included:

- a weekly briefing from the Chief Executive which updates staff on key developments and challenges facing the Trust, including financial and economic factors affecting the Trust's performance, and invites staff to feed back and engage with him directly
- a new monthly team briefing setting out matters of strategic importance which is cascaded from the Executive Team to every team at the Trust
- a new Connected monthly staff e-newsletter which looks at developments, achievements and development opportunities from a frontline perspective
- a central news and information resource on our intranet, Connect, enables staff to post news items and comments and responses to specific issues
- 'What's new this week', a weekly e-bulletin summarising all news and information from the past week in one place
- Dragons' Den, an opportunity for teams to pitch innovative ideas and projects to a panel comprising executive directors, non-executive directors, governors and service users, with the pitches filmed and shown on the Trust intranet to recognise the staff involved
- special thanks and recognition scheme (STAR), which allows staff to recognise when a good job has been done by a colleague by sending an e-card. The team with the most STAR cards in each month then has the opportunity to have 'Tea with the Chair' and spend time talking to our Chair about their work and any issues they have
- visits to teams from executive and non-executive directors
- 'Listen Up' Conversations where staff can go along and raise concerns and questions direct with an executive team member – 24 were held in 2017/18.
- our Working Better Together initiative, which involves staff directly in the performance of the Trust, through each staff member setting SMART objectives that relate to the objectives stated in the business plan
- involvement of staff across the organisation in the business planning process, with each service and corporate team developing its own business plan based on a bespoke strategic planning workshop

- Dear John, a stand-alone website that can be accessed from any PC inside or outside the Trust and allows staff to raise their quality concerns, anonymously if they wish, direct with our Chief Executive. In 2017/18, 111 submissions were received.
- Mental Health News, a round up of new publications and articles relating to mental health
- staff engagement meetings in service areas
- the Quality and Excellence Awards scheme, for which the fourth annual ceremony was held in September 2017. The cost of these awards is covered by sponsorship from carefully selected partner organisations.

In addition we run specific consultations for staff on key strategic programmes within the Trust. These have included the opportunity to directly input into development of these programmes and strategies via face-to-face sessions and the ability to comment on the intranet or by email. This year we have in particular involved staff in the development of the Trust's approach to safer search, care planning and medicines management.

Health and safety performance

In the last year, the focus of the work of the Health and Safety team has predominantly been around improving the fire safety management system in the Trust.

This has included the following:

- Delivering face to face fire procedure training to staff on their sites and testing the effectiveness of this training by conducting regular fire drills for inpatient units and community and office buildings. Staff have found these really beneficial in supporting them to safely evacuate service users if required.
- Developing a new, more robust process for ensuring that actions from fire risk assessments are being implemented effectively.
- There are now local Health and Safety Leads across the Trust, who are supporting the development of a positive safety culture at an operational level.
- The Health and Safety team has been instrumental in ensuring the development and delivery of relevant training to new line managers – this program commenced in January 2018.

Other key points to note for 2017/18 are:

- All environmental and ligature risk assessments for the Trust are in date, with all units' assessment now accessible on the Trust intranet. There is now a focus on ensuring that identified actions have been implemented.
- The Trust received no enforcement notices and had no Never Events in 2017/18.
- All Central Alerting System (CAS) alerts from the Department of Health were responded to within the given timeframe.
- In 2017/18 there were 16,222 reported untoward incidents (a decrease on 2016/17 by 1,261 incidents).
- Incidents of violence and aggression accounted for 3,960 in 2017/18, of this figure 1,598 were as a result of physical assaults. This compares with 4,096 in 2016/17, of which 1,584 were as a result of physical assaults.

- The number of false fire alarms reported in 2017/18 was 79, an increase of 23 on the previous year.
- The number of actual fires reported in 2017/18 was 14, a reduction from last year of three. Of these two were accidental, eight were wilful/arson and three undetermined.
- There were 78 staff) and 536 service user slips, trips and falls incidents in 2017/18. In 2016/17 there were 80 staff and 584 service users slips, trips and falls incidents. A slight increase of 5 per cent for staff and a decrease of 4 per cent for service users.
- Personal accidents to staff (excluding slips, trips and falls) accounted for 149 reported incidents which is a decrease of 51 from 2016/2017.

A total of 25 incidents were reported to the Health and Safety Executive under the requirements of RIDDOR in 2017/18.

Occupational health

As part of our People Plan we are committed to improving the health and wellbeing of our staff by ensuring they have access to services which support their health and wellbeing, encourage a healthy lifestyle and help reduce absence.

Since April 2016, our staff have had access to an integrated occupational health and wellbeing service. The service supports our commitment to providing staff with a joined–up and collaborative approach towards occupational health, neuro-musculoskeletal (physiotherapy) and employee psychological support and therapies, to gain maximum benefits for individuals.

Working closely with our occupational health provider we have delivered:

- 67 health promotion sessions across 14 locations
- 6 health and wellbeing (specific themed) workshops
- 617 staff engaged in the programme, plus 238 staff attended drop in sessions/ 1:1 health sessions
- 24 general health promotion sessions
- 16 know your number (KYN) sessions
- 16 resilience and mindfulness sessions
- 5 sleep 1-to-1 sessions
- a better backs workshop
- a sleep workshop
- a heart health workshop
- a weight management workshop
- two resilience workshops.

Feedback from health promotion events has been positive:

- 7 out of 10 found the events beneficial
- 71 per cent are likely to make positive changes following the events
- 88 per cent would recommend an event to a colleague.

Staff also have access to the Health Manager Wellbeing app and website which was launched in January 2017. This is a confidential online health and wellbeing resource that offers staff a combination of personally tailored programmes and general health information and support. To date, 679 staff are registered on Health Manager. Within Health Manager staff can:

- monitor exercise and activity levels
- take a wellbeing assessment to find out what they can do to improve wellbeing
- set targets and goals that can help improve wellbeing and fitness, and help lose weight
- find access to many health resources, including videos, articles and fitness programmes. The resources look at a variety of different areas including sleeping habits, how to manage any existing health conditions, how to improve energy levels and managing stress.

Countering fraud

Fraud in the NHS is a drain on the valuable assets meant for patient care and costs the health service a substantial amount. The situation is improving year on year as recovery of money, prosecution of offenders and awareness of the issue continues to build. However a considerable amount of money is still lost through patient, practitioner and staff fraud. The NHS Counter Fraud Service aims to reduce this to an absolute minimum, and maintain it at that level. The Trust has in place a team of Local Counter Fraud Specialists (LCFS) who are the first line of defence against fraud. Their role includes raising awareness of the risk of fraud among staff, reducing the risk through a programme of proactive work and, in the event of suspicion being raised, conducting formal investigations.

Staff survey

Summary of performance

	2016		2017		Trust improvement/ deterioration
	Trust	**National Average for Mental Health**	**Trust**	**National Average for Mental Health**	
Response Rate	39%	49%	44%	52%	5% improvement

A total of 1,625 staff completed the survey which gives us an overall response rate of 44 per cent, a significant improvement of five per cent since the previous year and a massive improvement of ten per cent since 2015 which when we first elected to undertake the staff survey electronically.

Top 5 Ranking Scores

		Our Trust in 2016	Our Trust in 2017	National Average for Mental Health	Trust improvement/ deterioration
KF2	Staff satisfaction with the quality of work and patient care they are able to deliver	3.90	3.83	3.83	0.07 deterioration
KF16	Percentage of staff working extra hours	75%	73%	72%	2% improvement
KF3	Percentage of staff agreeing that their role makes a difference to patients / service users	89%	87%	88%	2% deterioration
KF24	Percentage of staff / colleagues reporting most recent experience of violence	94%	92%	93%	2% improvement
KF27	Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	60%	60%	61%	0% no change

Bottom 5 Ranking Scores

		Our Trust in 2016	Our Trust in 2017	National Average for Mental Health	Trust improvement/ deterioration
KF9	Effective team working	3.65	3.62	3.84	0.03 deterioration
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	76%	71%	85%	5% deterioration
KF20	Percentage of staff experiencing discrimination at work in the last 12 months	20%	23%	14%	3% deterioration
KF23	Percentage of staff experiencing physical violence from staff in the last 12 months	4%	5%	3%	1% deterioration
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	28%	32%	21%	4% deterioration

The survey is a key part of the way we listen to the views of our staff so that we can make our Trust a better place to work. While there has been progress in some areas, overall the results are disappointing and show that a great deal of work remains for us to do.

Over the last 12 months we have implemented targeted health and wellbeing initiatives which have resulted in significant improvement in relation to staff perception of the organisation's interest in the health and wellbeing of our workforce. There is a need to now strengthen these initiatives further with more targeted support implemented in conjunction with service areas and to continue to focus on key areas such as stress and musculoskeletal, with service areas leading on the delivery of these plans.

Focused work around the Dignity at Work Programme combined with the policy launch and awareness sessions has had a strong impact in terms of raising awareness and encouraging staff to report bullying and harassment and violence in the workplace.

We have also undertaken significant work around the review and relaunch of staff networks, and various other initiatives as part of the equality delivery system (EDS2) and Workforce Race Equality Standard. This has provided a strong foundation to now embed this further and facilitate culture change through training, awareness and support to improve staff experience, create a culture of compassionate care, reduce bullying and harassment and promote equality in the workplace.

Following the last staff survey we have also implemented an innovative and evidence based approach around team effectiveness in conjunction with Aston OD. We have completed the recruitment and training phase of this project and are now in the process of piloting the programme prior to full roll out across the Trust. It is important this piece of work is fully embedded in order to evaluate the effectiveness of the programme and see any positive outcomes associated with the staff survey.

Following the publication of the 2017 staff survey in February 2018, the Board agreed the following priorities:

- Equality and diversity
- reducing violence against staff
- Improving team working
- Bullying and harassment

In addition to the actions already outlined above, in order to build an effective response we want to understand what staff have said in detail. We will therefore be closely analysing the data published along with the results from the spring 2018 quarterly ProActive Pulse Check and other engagement work such as Listen Up conversations.

That work will help us to develop a renewed set of actions based on staff feedback and involvement. This will build on existing activity outlined earlier and like last year will include targeted activity developed by service areas. The focus will be on what staff have told us in the survey and what more we need to do to work toward our strategic ambition to attract, develop and support an exceptional workforce.

Expenditure on consultancy

Expenditure on consultancy in 2017/18 was £263k, compared to £413k in 2016/17.

High paid off-payroll engagements

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months

Number of existing arrangements as of 31 March 2018	7
Of which:	
Number that have existed for less than one year at time of reporting	0
Number that have existed between one and two years at time of reporting	9
Number that have existed between two and three years at time of reporting	7
Number that have existed between three and four years at time of reporting	7
Number that have existed for more than four years at time of reporting	2
Confirmation that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and where necessary that assurance has been sought.	Yes

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration between 1 April 2017 and 31 March 2018	0
Number of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and national insurance obligations	0
Number for whom assurance has been requested	0
Of which:	0
Number for whom assurance has been received	0
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not being received	0

In any cases where, exceptionally: • the Trust has engaged without including contractual clauses allowing the Trust to seek assurance as to their tax obligations; or • where assurance has been requested and not received, without a contract termination please specify the reasons for this	Assurance in ALL cases is requested at the time the contractor is set up on our systems. Payments will NOT be made under any circumstances unless assurance is received. This forms part of our 'supplier set-ups'.

For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

Number of off-payroll arrangements of Board members, and/or senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed "Board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements	33

In any cases where individuals are included within the first row of this table, please set out	
Details of the exceptional circumstances that led to each of these engagements	Not applicable to this reporting period.
Details of the length of time each of these exceptional engagements lasted	Not applicable to this reporting period.

Our Trust's policy on the use of off-payroll arrangements

As part of the *Review of Tax Arrangements of Public Sector Appointees* published by the Chief Secretary to the Treasury on the 23 May 2012, departments and their arm's length bodies, including foundation trusts, must publish information in relation to the number of off-payroll engagements – at a cost over £245 a day for six or more months. Since May 2012, appropriate processes have been in place to ensure that any new off payroll engagements, whether direct contractor or agency staff, have contractual arrangements in place and provide appropriate evidence to demonstrate that they pay UK Tax and National Insurance. This evidence consists of assurance via a signed declaration that the direct contractor or agency staff member is compliant with HMRC regulations for PAYE and national insurance purposes.

Exit packages

The termination benefits disclosed below all relate to compulsory redundancies and other agreed departures (mutually agreed resignation scheme). Of the disclosed termination payments none were non-contractual payments requiring HM Treasury approval. This was also the case in 2016/17. There were no termination benefits paid or due in the reporting year to key management personnel, who are defined to be the Board of Directors of the Trust. This was also nil in 2016/17.

Staff exit packages 2017/18

Exit package cost band	Number of compulsory redundancies 2017/18	Number of other agreed departures 2017/18	Total number of exit packages by cost band 2017/18	Total number of exit packages by cost band 2016/17
<£10,000	2	2	4	3
£10,000 - £25,000	-	2	2	1
£25,001 - £50,000	2	2	4	8
£50,001 - £100,000	1	3	4	3
£100,001 - £150,000	-	-	-	5
£150,001 – £200,000	-	-	-	-
Total number of exit packages by type	5	9	14	20
Total resource cost £'000			450	1,079

Staff exit packages 2016/17

Exit package cost band	Number of compulsory redundancies 2016/17	Number of other agreed departures 2016/17	Total number of exit packages by cost band 2016/17	Total number of exit packages by cost band 2015/16
<£10,000	0	3	3	1
£10,000 - £25,000	1	-	1	3
£25,001 - £50,000	3	5	8	1
£50,001 - £100,000	2	1	3	0
£100,001 - £150,000	5	-	5	2
£150,001 – £200,000	0	-	0	0
Total number of exit packages by type	11	9	20	7
Total resource cost £'000		-	1,079	336

NHS Improvement's Single Oversight Framework

Single Oversight Framework

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

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

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

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

Segmentation

NHS Improvement has placed Birmingham and Solihull Mental Health NHS Foundation Trust in Segment 2.

What being in Segment 2 means:

"Providers offered targeted support: there are concerns in relation to one or more of the themes. We've identified targeted support that the provider can access to address these concerns, but which they are not obliged to take up. For some providers in Segment 2, more evidence may need to be gathered to identify appropriate support".

NHS Improvement has not taken any enforcement action against the Trust and no actions are being taken or proposed by the Trust.

This segmentation information is the Trust's position as at 18 April 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

Area	Metric	2017/18 scores				2016/17 scores	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial sustainability	Capital service capacity	3	4	4	4	4	4
	Liquidity	2	2	2	2	2	2
Financial efficiency	I&E margin	1	2	3	2	2	4
Financial controls	Distance from financial plan	1	1	1	1	1	1
	Agency spend	1	1	1	1	2	2
Overall scoring		2	3	3	3	3	3

Statement of chief executive's responsibilities

as the accounting officer of Birmingham and Solihull Mental Health NHS Foundation Trust

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require 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 required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of 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 *Department of Health Groups Accounting Manual* and in particular to:

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

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

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

Signed:

John Short, Chief Executive
Birmingham and Solihull Mental Health NHS Foundation Trust Date: 23 May 2018

Annual governance statement

Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with these responsibilities I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

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

Capacity to handle risk

The executive director on the Trust Board with overall accountability for risk management is the **Director of Nursing** who is supported by the Associate Director of Governance and Governance team. These responsibilities include health and safety, safeguarding children, safeguarding vulnerable adults, infection control and complaints. The Director of Nursing is also the registered officer with the CQC and responsible for ensuring compliance with CQC regulations.

Executive and Trust Board Level

The **Chief Executive** maintains overall accountability for risk management within the Trust, but will delegate responsibility to nominated executive directors of the Trust Board.

The **Director of Nursing** (on behalf of the Chief Executive) is the executive director responsible for co-ordinating the management of clinical and non-clinical risk and for ensuring that risks are escalated through the risk management governance structure.

The **Medical Director** and the **Director of Nursing** have joint delegated responsibility for clinical risk management and jointly chair the Clinical Governance Committee.

The **Director of Finance** has delegated responsibility for internal financial controls and the implementation of financial risk management, information management systems, business planning, information governance, communications, the programme management office, property and facilities.

The **Chief Operating Officer** is responsible for the management and co-ordination of all operational risks, together with risks relating to human resources and staffing. The Chief Operating Officer also holds accountability for local security management arrangements and has delegated responsibility for managing risks associated with the recruitment, retention, training and development and remuneration of our workforce.

Reporting to the Chief Operating Officer, **Associate Directors of Operations** are responsible for the operational performance of their services, **Clinical Directors** are responsible for clinical quality and governance for their areas. Other professional heads have responsibility for the systems of risk management at service area level and lead their implementation.

Associate Directors of Operations/Clinical Directors/ Heads of Service are responsible for:

- implementing Trust approved operational policies, standards, guidelines and procedures within their area of responsibility and ensuring these are understood by staff
- ensuring that risk assessments are undertaken liaising with appropriate professionals as appropriate
- ensuring that an up to date record of staff's attendance at, and compliance with, statutory and mandatory training is maintained as per the Risk Management Training Policy
- implementing and monitoring any identified, and appropriate, control measures to mitigate risk within their scope of responsibility
- ensuring that identified risks are recorded on the risk register as appropriate within their domain and reported through local governance structures to the Clinical Governance Committee on a quarterly basis
- overseeing the development and monitoring of an action plan to mitigate identified risks on the risk register.

Other responsibilities are outlined within the policy:

The Integrated Quality Committee (IQC), chaired by a non-executive director, was established by the Board to provide assurance on the effectiveness of quality and safety, drive forward improvements to ensure the highest possible quality of services and ensure that implications of financial decision making on quality and safety of services is taken into account

The **Director of Finance** is the Senior Information Risk Owner and co-chairs the Information Governance Steering Group with the **Medical Director**, who is the Caldicott Guardian. The **Associate Director of Estates and Facilities,** reporting to the Director of Finance, has overall responsibility for the Trust estate, plant, waste management and environmental management.

The **Company Secretary** has overall responsibility for the reporting to Trust Board of the Board Assurance Framework, reflecting the high level risks identified in Trust risk registers and any other risks identified by the Board which threaten delivery of strategic objectives.

A primary focus of the Board has been to promote openness and transparency to reinforce the process of escalation of concerns and risks. This is reinforced through Trust Board communications and Trust Board visits (see below for further details set out in the risk and control framework).

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 core competences in relation to risk management. The statutory and mandatory training programme reflects all key training requirements for risk management for all staff within the organisation. These requirements are identified having been appropriately risk assessed and systems are in place to monitor compliance with these requirements. The Trust has a real time system to monitor all staff compliance with training requirements.

This is reinforced through our regular management supervision process and as a result high levels of compliance are achieved.

Senior managers are required as part of the statutory and mandatory training programme to attend three yearly updates on risk and this particularly focuses on recent NHS best practice and risk assessment.

The Risk and Control framework

The Risk Management Policy was updated and approved in November 2017. The policy was strengthened to provide clarity on risk scoring methodology in line with best practice developed by the National Patient Safety Agency; and further clarified roles and responsibilities of individuals as well as the governance route for escalating and considering risk. There were also some changes to reporting details. The Trust's approach recognises the need to ensure that risks are openly discussed and reported within a culture of improvement, honesty and reality; as well as the need to strike a balance between stability and innovation. The Trust uses a standard 5x 5 matrix for risk scoring.

All local service areas and executive directors are expected to systematically review risks on their risk registers on a quarterly basis and provide assurance that the risks are being managed through their local Integrated Quality Groups. Where risks cannot be managed, this should be escalated to line managers.

Any risks of 15 and above are reported to the Clinical Governance Committee on a quarterly basis, at which point moderation may take place. This is to determine whether or not these risks could impact on the delivery of the corporate objectives and business plan and which therefore need to be reflected on the Corporate Risk Register, presented quarterly in full to the Integrated Quality Committee and the Finance, Performance and Productivity Committee, and from there to the Board as part of the Board Assurance Framework (BAF). Annual assurance is provided to the Audit Committee.

There was a wide-ranging review of the Trust's approach to strategic risks and steps taken to ensure that the BAF more accurately reflected these. A number of strategic risks were added during 2017/18. The Trust received reasonable assurance in the internal audit on the BAF and risk register. To further support its development there was regular discussion at Board and Committee meetings throughout the year.

Each director is accountable overall for maintaining a risk register for their responsibilities.

Core risk management responsibilities sit as follows.

The Board is responsible for:

- approving the overall framework for Risk Management across the Trust including approval of the Risk Management Policy
- reviewing risks with a score of 15 and above as part of the BAF and providing robust constructive debate on the effectiveness of risk mitigation.

The Audit Committee is responsible for:

- reviewing the effectiveness of the system of internal control for risk management
- producing the Annual Governance Statement for approval by the Board.

The Integrated Quality Committee is responsible for:

- reviewing the full high level risk register to ensure that this is reflective of quality, safety, and workforce outcomes for the Trust
- reviewing the effectiveness of mitigating controls in managing risk
- providing assurance of the credibility of the risk register content to the Board via the BAF.

The Finance, Performance and Productivity Committee is responsible for:

- reviewing the full high level risk register to ensure that this is reflective of performance and financial sustainability outcomes for the Trust
- reviewing the effectiveness of mitigating controls in managing risk
- providing assurance of the credibility of the risk register content to the Audit Committee.

The Clinical Governance Committee is responsible for:

- reviewing all local service area risks with a score of 15 or above and for applying risk moderation to determine the level of impact that these risks may have on delivery of corporate objectives. Where a significant impact is identified, the Clinical Governance Committee will escalate such risks to the High level risk register.

The Programme Management Board is responsible for:

- reviewing all programme group risks linked to change programmes with a score of 15 and above and for applying risk moderation to determine the level of impact that these risks may have on delivery of corporate objectives. Where a significant impact is identified, the Programme Management Board will escalate such risks to the high level risk register.

Local Clinical Governance Committees/Trustwide Governance Groups/ Programme Groups are responsible for:

- reviewing all local and service/project specific risks and ensuring that these are documented on local risk registers
- identifying and tracking the implementation and effectiveness of risk mitigation actions to demonstrate dynamic risk management
- escalating risks with a score of 15 and above to the Clinical Governance Committee or Programme Management Board as appropriate

Governance

The principal committees of Trust Board and their responsibilities are set as follows.

Audit Committee

The role of the Audit Committee is to oversee arrangements and review findings for:

- governance, risk management and internal control
- internal audit
- external audit
- other assurance functions
- the process for managing risks is sound.

Integrated Quality Committee

The role of the Integrated Quality Committee is to:

- provide assurance to the Board on the effectiveness of the quality and safety of services and to ensure regulatory compliance in respect of quality
- ensure that the Trust is aiming to achieve the highest standards of quality around safety, service user experience and clinical effectiveness as outlined in the Well Led Framework, the Quality Strategy and Quality Accounts.

Remuneration Committee

The role of the Remuneration Committee is to review reports on:

- appraisal and approve remuneration of the Chief Executive, Executive Directors and Company Secretary
- annual benchmarking data related to remuneration of Board level positions
- ensure appropriate arrangements are in place and followed with regard to termination of Board Executive Director appointments
- ensure all provisions regarding disclosure of remuneration including pensions of Board Directors are fulfilled.

Finance, Performance and Productivity Committee

The role of the Finance, Performance and Productivity Committee is to:

- consider the Trust's medium and long term financial strategy and financial health
- approve business cases in line with authority limits defined by the scheme of delegation or make a recommendation to the Board for matters reserved to Board
- monitor progress of major capital investments and the short, medium and long term capital programme
- maintain an oversight of, and receive assurances on, the robustness of the Trust's key income sources, including new business tender submissions
- consider savings targets and plans and endorse them for approval by the Board. Also to monitor progress against the cost improvement programme
- consider the Trust's approach to tax
- approve and keep under review the Trust's investment strategy and policy
- receive regular reports and insights regarding organisational performance in a form determined by the Committee, including external benchmark information as an aid to improving overall performance and productivity of the Trust
- review relevant high level risks and escalate to IQC and Audit Committee as appropriate in order to ensure these are properly reflected in the BAF
- scrutinise and challenge financial information and service redesign plans and ensure that any potential impact on quality is fed back to IQC
- seek assurance regarding the operational delivery of ICT, its impact on users and plans for sustaining it

Mental Health Legislation Committee

The role of the Mental Health Legislation Committee is to:

- provide assurance to the Board on all matters related to the administration on mental health legislation with reference to guiding principles laid out in the Code of Practice
- monitor and scrutinise the result of CQC visits and other relevant external reports
- review assurance there are an appropriate number of suitably skilled and qualified Lay Managers in place within the Trust
- approve mental health legislation related policies and procedures and scrutinise their application
- continually assess and review risks to compliance with Mental Health Act legislation.

Charitable Funds Committee

The role of the Charitable Funds Committee is to:

- ensure fund objectives and spending plans are appropriate and in line with objectives, spending criteria and priorities set by donors and sources are acceptable to Trustees and respond to bid submissions
- oversee approach to investment ensuring the investment policy is implemented
- ensure appropriate systems of control over income and expenditure and that there are robust governance processes in place.

Each committee undertakes an annual review of its performance against the work plan of the committee and provides an update to the Board following each meeting.

The Trust has continued to apply the well led framework which contributed to the development and implementation of the Trust's Quality Strategy and the Board has carried out regular self-assessments against the framework. Following CQC's inspection of services in the spring of 2017, the Board is considering a more formal review and assurance.

The principle of learning lessons is emphasised and has been further strengthened during the course of the year and to support assurance an integrated quality report has been received at each Integrated Quality Committee meeting which provides an overview of aggregated intelligence arising from incidents, regulators, complaints, inquests and litigation by quarter. The document identifies the volume of intelligence being reported within the Trust, alongside the underlying issues of risk to be addressed moving forward.

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. New, externally facilitated training has been put into place for those taking place in leading serious incident investigations and a new process established which includes greater Executive oversight and involvement at the weekly Serious Incident Review Group. The Trust has also worked closely with the Patients Association in terms of complaints investigation.

The Trust aims to systematically review and learn from untoward incidents and complaints. Good practice and changes to policies are communicated through email, intranet, service area reports, newsletters and team briefs. During the year we have developed some new mechanisms for learning including a pilot of 'learning lessons lunches' and the launch of three minute videos focusing on lessons learnt from serious incidents, complaints and clinical audit. This has proved to be a successful learning tool which is accessible via our intranet to all staff. A number of actions have been taken through our internal risk alert process to ensure that services confirm changes required.

All performance information in relation to the Trust's priority indicators are reported to the Integrated Quality Committee and Finance, Performance and Productivity Committee. Each report includes a RAG rating of data accuracy reflecting entry accuracy, timeliness and reporting accuracy.

In line with its strategic framework and values the Trust has further sought to ensure a culture of openness and empowerment to its staff. This is intended to ensure that risks can be promptly identified and responded to. This is reinforced in a range of ways including:

- promotion of incident reporting. The Trust actively seeks to increase the level of incident reporting – particularly for non-nursing staff groups who tend to report less. The latest NRLS data demonstrates that the Trust is in the middle 50 per cent of reporters of incidents nationally, with lower levels of harm than are typically seen in other Trusts.
- weekly feedback brief sent to all staff from the Chief Executive
- high Board level presence within clinical teams and departments

- the reinforcement of the 'Dear John' process which enables any member of staff to anonymously raise a quality concern directly to the Chief Executive
- the reinforcement of the role of the Freedom to Speak Up Guardian
- delivery of a range of staff engagement activities which build on our previous work to to regularly promote staff engagement and recognition activities and events at the Trust.

Assurance in relation to CQC regulation requirements is led by the Executive Lead, Director of Nursing and Associate Director of Governance. Our internal approach to peer review against the regulatory framework called 'A Time to Shine' enables a much greater level of local understanding of regulatory requirements and compliance with teams being empowered to regularly self-assess compliance resulting in the sharing of good practice and the development of local improvement plans. The self-assessment is then supplemented by an 'expert subject matter team' which visits each part of the Trust to give objectivity and advice to service areas. This revised approach has given local teams an ongoing systematic method of measuring and testing their compliance with the regulatory framework. Compliance around core policies areas which support our regulation compliance is also identified in each individual policy with a programme of monitoring and review.

The Trust learns from good practice through a range of mechanisms including national guidance / alerts, benchmarking, clinical supervision and reflective practice, individual and peer reviews, performance management, continuing professional development programmes, clinical audit and application of evidence-based practice and meeting risk management standards. Significant this year has been our work in developing a Mortality Surveillance Group to take forward the requirements of the National Framework for Mortality and the Trust has facilitated and been commended for its work in facilitating regional workshops led by Mazars.

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.

The focus of investigations around serious incidents is to identify system failures which can then be addressed through action plans. The Trust actively promotes a systems approach to incidents to ensure appropriate risk reporting and support teams to address weaknesses when identified.

Data security risks: The Trust actively monitors and manages its information governance (IG) compliance through the IG assurance framework as stipulated in policy, reporting up to the Information Governance Steering Group (IGSG), which is co-chaired by the Senior Information Risk Owner (SIRO) and the Caldicott Guardian. The IGSG monitors the Trust's compliance with the HSCIC IG Toolkit, approves the IG work plan that is developed year on year, reviews incidents where they occur and looks to recommend improvements to increase compliance.

The Trust has implemented a full range of technical and organisational measures in line with national best practice, has a suite of information governance (IG) related policies, procedures and guidance documents which are made available to all staff in a variety of ways and ensure staff are appropriately trained in IG.

Communicating IG to Trust staff is an on-going and extremely important process in ensuring staff are aware of their responsibilities, as detailed in these documents. Where failings are found to occur investigations are carried out, lessons learnt and recommendations made and implemented where appropriate. Significant work has been completed this year in preparation for the introduction of the General Data protection Regulation in May 2018.

The major risks are considered as those rated at 15 or above at a corporate level on the standard 5 x 5 matrix for risk scoring. These risks are identified through the risk management process and are reflected in the BAF. The major risks identified by the Trust are as follows:

Financial	Risk of increased cost pressures due to : • potential for secure services to miss savings targets; • Renewal of Microsoft licences in 2019 at significantly increased price.
Capacity	Risk of insufficient capacity across the acute care pathway/assertive outreach pathway resulting in difficulties in managing inpatient admission.
Staffing	Risk of patient care being compromised by lack of available staff with the additional cost pressure to the Trust of using agency staff.
Violence to staff	Risk of aggression from Older Adult patients resulting in harm to staff. Further impact on morale/staff absences creating pressures on delivering patient care and increased use of agency staff.
HMP Birmingham	The overall risk of violence, abuse and harassment to healthcare staff at the prison has increased since the riots of December 2016. There is a more specific risk that use of legal highs within the prison may result in serious harm or death of a prisoner. There is a further risk to prison officers/healthcare staff responding to these incidents including emotional harm and physical harm from a) violence from an intoxicated prisoner and b) passive exposure to legal highs. This in turn could lead to a reduction in staff ability to carry out other duties.
EPMA	Risk that issues with the new EPMA system may lead to difficulties with issuing new prescriptions in certain areas or the issue of duplicate prescriptions leading to a potential for patient overdose.
Waiting times	Risk of inability to monitor waiting time levels due to lack of monitoring system. Risk of waiting list for care-coordinators impacting on service users who are stepping down from HTT or inpatient care.

All risks identified above are considered as in year and future risks relating to the Strategic Objectives pertinent to 2017/18.

<u>Actions to address:</u>

Close working with commissioners and other care partners.
Through its risk management policies the Trust Board promotes open and honest reporting of incidents, risks and hazards.

Use of a nationally recognised risk rating tool, supported by agreed assurance level definitions ensures a standard approach is taken to prioritising risks.

The Trust Board has kept under review its arrangements in relation to the NHS foundation trust condition 4 (FT governance). As identified above, each committee reviews its own effectiveness and the Board sub-committees have provided annual reports to the Audit Committee. The Board has held sessions with the governors on a range of issues and with the senior leadership team.

The Audit Committee ensures that any actions identified in the Corporate Governance Statement are reviewed and met.

The Trust policy management framework provides a standard process for the development, approval and review of all Trust policies. Inherent in this is the requirement for equality impact assessments to be undertaken on all policies. Compliance with all the requirements have to be demonstrated to the Clinical Governance Committee or alternative approved ratifying committee before a policy is approved.

The **Programme Management Office (PMO)** has developed a structured project management approach to all significant new developments and potential saving schemes which are required to demonstrate how risks are managed. All projects are reviewed through the Programme Management Board. Integral to each project is the requirement to produce a detailed quality impact assessment. These are required to be approved by the Director of Nursing and Medical Director and approved by the Programme Management Board before projects can proceed.

The focus on training in relation to incident investigations is the use of root cause analysis techniques; this reinforces a positive learning approach with the emphasis on system improvement rather than individual blame.

There are a range of formal mechanisms for engaging with partner organisations, governors, service users and the wider public, ensuring that risks are fully understood and are embedded into business planning and performance management processes.

The Trust works closely with key stakeholders and there are a number of joint structures that already exist between agencies (e.g. strategic partnership boards and commissioning committees). The Trust will endeavour to involve partner organisations in all aspects of risk management.

Engagement of service users and carers is key to our success. The Trust moves forward in this commitment through a number of initiatives. These include all aspects of service design, the mechanisms through which we hear and respond to user and carer feedback and all initiatives embedding recovery throughout services. Co-production and co-design sit at the heart of the Trust's commitment, and throughout the year we have sought to embody this as we create opportunities for people with lived experience of mental ill health to take an active part in all elements of delivery and design, as equal partners.

The Trust is fully compliant with the registration requirements of the Care Quality Commission and was awarded an overall rating of Requires Improvement following the Chief Inspector of Hospitals inspection in 2017, although a number of significant improvements have been acknowledged since then. At the time of writing this statement, seven of the Trust's nine core services have a rating of 'Good'.

The Trust has a good relationship with the Care Quality Commission and has received 32 inspections during 2017/18in relation to Mental Health Act compliance. The learning from MHA inspections helps the Trust to continually improve its services.
Issues raised during 2017/18 have related to consent, cancellation of s17 leave and the poor completion of s17 documentation.

All CQC activity is monitored through the Mental Health Legislation Committee and Clinical Governance Committee with themes being reported to the Integrated Quality Committee.

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.

The Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. Our Sustainable Development Strategy is valid until 2020 and sets an overview of responsibilities for carbon management and sustainability

To enhance the above and taking into account the needs for resilience and Climate Change adaption the Trust's Energy and Environment Manager has chaired a multidisciplinary group (with external specialist advisors) to compile a draft Sustainability and Resilience Action Plan that details responsibilities and actions necessary to address matters including the need for climate change adaption. The plan also includes a review of the geography of the estate in terms of weather extremes and adaption 'hot spots' that will support both the Estates Strategy and service delivery strategies

The Equality, Diversity and Inclusion Framework was improved in 2017 and progress has been monitored through the Workforce Development Committee. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Much work has been undertaken in 2017/18 and the Trust now has a full Equality Action Plan leading from the Framework. This is reflected in the People Strategy and Plan approved by the Board in March 2017.

Review of economy, efficiency and effectiveness of the use of resources

As the economic climate within the NHS becomes more challenging it will be essential that we continue to focus on and can demonstrate value for money of our services.

As the economic climate within the NHS becomes more challenging it will be essential that we continue to focus on and can demonstrate value for money of our services.

For 2017/18, we ended the year with a Single Oversight Framework segment of 2. We achieved this rating in a year where the cash releasing efficiency savings were set at a particularly challenging level and still invested in our estate, where we have completed considerable work on statutory standards and backlog maintenance and minor schemes to improve the service user environment and our IT infrastructure including mobile working equipment which will support our staff to deliver services and to generate future efficiencies.

During 2017/18, we have used a range of methods to identify and deliver efficiency savings, including new business development, redesign of service user pathways and process improvements. We are committed to enhancing our approach to productivity and efficiency and this will be a key element of our planned Quality Improvement Programme.

Internal Audit

The Head of Internal Audit has provided me with an overall opinion for 2017/18 of 'reasonable assurance' that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Internal Audit carried out 15 audit reviews for 2017/18 (12 assurance reviews, two advisory reviews and one follow-up review). The 12 assurance reviews were designed to ascertain the extent to which the internal controls in the system are adequate to ensure that activities and procedures are operating to achieve the Trust's objectives. For each assurance review an assessment of the combined effectiveness of the controls in mitigating the key control risks was provided. One report was issued with a 'substantial assurance' opinion, 10 with 'reasonable assurance' and one with 'limited assurance'. The remaining three reports were advisory or follow-up reports without an overall assurance opinion.

- There was one area reviewed by internal audit, where it was assessed that the effectiveness of some of the internal control arrangements provided 'limited assurance'. This was in respect of Transport-Taxis. The limited assurance opinion was based on the following key findings at the time of the audit fieldwork:
    - Areas of common non-compliance with Trust policy were identified. The current systems and controls require review to ensure compliance and support by an adequate audit trail; centralisation of control may be warranted.
    - Some taxi usage for service users and staff was identified at ward and corporate level, where the need for levels incurred was questionable; clarification of approved practice is required.

- Information needs require agreeing with Associate Directors / managers to improve monitoring and reporting.
- Staff awareness of the Non-Emergency Patient Transport (NEPT) service and other cost-effective options available appeared to be low.
- Cost-benefit analysis of increasing capacity and expanding the NEPT service should be undertaken.

Management has accepted all of the above recommendations and signed up to formal action plans to address the significant control weaknesses in these areas.

Risk Management arrangements and Board Assurance Framework Review – It is my opinion that we can provide reasonable assurance that the Assurance Framework is sufficient to meet the requirements of the 2017/18 AGS and provide a reasonable assurance that there is an adequate and effective system of internal control to manage the significant risks identified by the Trust. There were no high priority recommendations.

Basis for the Opinion

The basis for forming this opinion was:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
2. An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

Information Governance

In 2017/18, the Trust has reported three level 2 incidents to the Information Commissioner's Office (ICO), the details of which including ICO action is outlined below where applicable.

1. 17 August 2017 - Staff member used social media app Snapchat to send a picture of a patient's record held on RiO, the patient's name and sensitive clinical information were included. Staff member was suspended pending disciplinary investigation.
   ICO decided not to impose any regulatory action upon the Trust but advised the Trust to conduct a social media awareness campaign to staff.

2. 4 September 2017 - Patient raised concerns that a staff member had breached their confidentiality by disclosing information to the staff member's sister and their former partner. Staff member was removed from duties involving access to patient information and access to clinical systems and was suspended pending disciplinary proceedings.

   ICO were provided with the outcome of the disciplinary which included the staff member being given a final written warning to cover a period of 24 months.

   ICO confirmed that the actions taken by the Trust were proportionate to any sanction that may be imposed by a court for an offence of this nature. As a result the ICO confirmed that no further action would be taken against the individual and the case was closed.

3. 25 January 2018 - Hardware failure on the EEG (Electroencephalogram - monitors brain activity) server in November 2017 resulting in a loss of 2 out of the 24 hard drives that are installed on the server. Data loss was due to technical issues (server failure and insufficient back up facilities in place). Data relating to 260 individuals were lost. The data concerned relates to video records and contemporaneous EEG records for the period 05/01/2016 – 28/12/2016 for 113 Service Users admitted for video telemetry (VT) investigations, a further 7 who will have had home VT and 140 outpatients who had routine EEGs.

   A Serious Incident (SI) review meeting was held on 28th March 2018 in line with Trust policy and the SI report will be forwarded to the ICO on completion. This incident is currently open with the ICO.

The Trust's information governance (IG) framework is supported by professionally led qualified staff and a committee structure which actively monitors and manages its IG compliance through the IG assurance framework, reporting up to a senior group – Information Governance Steering Group (ISGS) chaired by the Caldicott Guardian and/or Senior Information Risk Owner (SIRO).

There has been continued progress in the comprehensiveness, rigour and quality of the Trust's IG arrangements during 2017/18 and a high IG toolkit submission rate.

Annual Quality Report

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

Quality report priorities and core indicators reported in the quality report have been an integral part of the routine governance processes over the year. Key indicators have been routinely reported to the Trust Board and the Integrated Quality Committee through the year, reflecting wider review and monitoring undertaken by the Trust.

The quality report has been developed subject to a wider consultation process involving staff, Council of Governors, service user and carer groups and commissioners. This has included regular reports being presented to governance committees and commissioners (through the Clinical Quality Review Group). A new Quality Strategy was approved by the Board in March 2017.

Progress against quality goals has been received at both IQC and the Board throughout the year.

There have been improvements in the majority of our quality goals when compared to the 2016/17 outturn position. We are however facing challenges in achieving the overall target levels set at the start of the year in some indicators including assaults between patients on our inpatient wards and also levels of prone restraint.

The quality goals for 20118/19 have now been considered by our Clinical Governance Committee, Council of Governors, Integrated Quality Committee and Board. Goals include those which have not been achieved this year and also reflect some additional improvement areas relating to family and carer involvement and engagement. We know that we need to improve in this area as this is a learning point from our serious incidents and mortality case note reviews.

Quality priorities for the year ahead defined within the quality report were developed from the Trust business planning process with local service areas and have subsequently been reviewed as part of a wider consultation process.

The Trust continues to meet the following national mental health access and waiting time standards:

- 75 per cent of people referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within 6 weeks of referral, and 95 per cent will be treated within 18 weeks of referral.
- The Trust consistently achieves and exceeds both IAPT access targets.
- More than 50 per cent of people experiencing a first episode of psychosis (FEP) will be treated with a NICE approved care package within two weeks of referral.
- Due to revised commissioning arrangements introduced from 1 April 2016, the Trust has responsibility for service users over the age of 35 and for Solihull residents of any age.
- The Trust met the national access standard in 2017/18.
- Children and young people (up to the age of 19) referred for assessment or treatment for an eating disorder will receive NICE approved treatment with a designated healthcare professional within one week for urgent cases and four weeks for every other case.
- As at the end of March 2018, the Trust has achieved this access target. Due to revised commissioning arrangements for services to children and young people in Birmingham, the Trust largely only provides this service for Solihull residents.

Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee [and risk/ clinical governance/ quality committee, if appropriate] and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Audit Committee has an annual programme of work related to identified Trust priorities. All work undertaken by internal and external auditors is reported through the Audit Committee to ensure that a full assessment of effectiveness is achieved.

Other explicit review/assurance mechanisms which support these activities include:

- the Trust Clinical Audit programme which is approved by Trust Board Integrated Quality Committee.
- annual programme of risk assessments
- reviews against regulation requirements
- serious incident reviews
- compliance programme and quality support team visits
- business plan review meetings.

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

Conclusion

There are no other significant internal control issues identified and the Trust believes that by addressing these issues it will have a system of internal control that supports the achievement of the organisations plans, aims and objectives.

Signed:

John Short, Chief Executive
Birmingham and Solihull Mental Health NHS Foundation Trust Date: 23 May 2018

Quality report

Section one

Statement on quality from the Chief Executive

Thank you for taking the time to read our quality account. This document is a report about the quality of services provided by our Trust as an NHS mental health provider of care. The report is published annually and is available to the public. Quality accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

Within this report we describe the work we are doing to improve patient safety, clinical effectiveness and the experiences of people using our services. We have welcomed the involvement and feedback made by our local stakeholders during the development of this quality account. We are once again also grateful for the valuable contribution made by our Foundation Trust's Council of Governors to this report.

This document outlines the good work that has been undertaken in our Trust over the past 12 months in improving the quality of our services. It also identifies areas that have been more challenging. We explain our plans for the next 12 months to address these more challenging areas as well as some new plans that we have set for ourselves to further improve the quality of care that our service users and their families and carers receive.

2017/18 has been a very busy year for us and I am delighted that we have achieved a number of the quality goals that we set out to deliver at the start of the year. I would like to take this opportunity to personally thank all of my c4,000 colleagues who make up our team here at the Trust for their ongoing hard work, compassion and commitment. I am very proud of the caring and professional way in which they support our service users.

We know that we make a significant positive difference to the lives of thousands of our service users every day, however we are not complacent enough to believe that we get this right every time. We listen to feedback from service users, families and carers as part of our day-to-day approach of understanding their experiences. We use this feedback to understand where things have gone well and when things have gone wrong. We work to ensure that improvements are made and in this document we aim to tell the story of our continuing efforts to provide services that meet the needs and wishes of those that we serve.

Twelve months ago we set ourselves some ambitious goals to further improve the safety, experience and effectiveness of care received by our patients. This quality account details our progress against each of these goals and provides supporting narrative. In essence whilst we have not always achieved the target levels that we set ourselves, we can see demonstrable improvement across many areas. In summary we have achieved the following improvements in comparison to our position 12 months ago:

- Just over 10 per cent reduction in the number of physical assaults on staff compared to 2016/17.
- A reduction in the number of Prevention of Future Death reports issued by the Coroner from three in 2016/17 to one in 2017/18.
- A slight reduction in the number of suicides on our community caseloads.

- Implementation of mortality case note review and avoidability scoring.
- Average harm levels of 23 per cent resultant from incidents occurring in our services compared to a national average harm level of 35 per cent.
- A reduction in the percentage of service users failing to return from section 17 leave within their prescribed timeframe from 1.54 per cent in 2016/17 to 0.54 per cent in 2017/18.
- The opening of our Recovery College in Solihull.

Areas where we have seen improvement but have not achieved the target we set include:

- Incidents of restrictive practice reducing to 4,317 incidents compared to 4,430 in 2016/17.
- Inpatient suicides have reduced from two incidents in 2016/17 to one incident in 2017/18.
- Recording of cardio metabolic indicators is improving compared to the start of 2016/17.
- The number of falls resulting in serious harm has more than halved compared to 2016/17 with two cases reported in 2017/18 compared to five in 2016/17.
- We have commenced the development of an integrated performance report in readiness for piloting in 2018/19.
- We went out to tender for an expert partner in Quality Improvement.

Areas of challenge have been:

- The number of physical assaults patient on patient has increased compared to 2016/17 with 544 incidents reported compared to 488 last year.
- We did not achieve the improvements that we planned in relation to the National Patient Survey results for the overall experience of patients in our care.
- The number of falls across the Trust increased from 358 in 2016/17 to 547 in 2017/18 – with a particular increase in adult acute wards.
- Timely communication with GPs remains a significant challenge.

As we did not meet all the target levels we set last year we are reviewing our planned interventions in these areas and will seek new approaches to achieving these targets which will remain our targets going forward. Violence and aggression still remains a threat to the safety of patients and staff on our inpatient wards and whilst we saw a reduction in incidences of assault on our staff, we unfortunately experienced an increase in assaults between patients on our inpatient wards. In 2017/18 we will be doing more to help patients and staff feel safer, by continuing to press forward with our Positive and Proactive Care Strategy which includes a range of evidence based interventions to reduce violence that are being embedded into practice.

We also need to ensure that we consider and record the physical health status of our patients more systematically and consistently. Whilst we have considerable improvement in this area in 2017/18 there are certainly opportunities for us to improve further over the next 12 months.

This year we have worked closely with our commissioners across Birmingham and Solihull to continually evaluate and review the quality of care delivery from the Trust through a monthly Clinical Quality Review Meeting. We have worked closely with our commissioners on a range of events to promote learning including suicide prevention and mortality.

Our regulators, the Care Quality Commission conducted a full hospital inspection at the end of March 2017. We received our report in the summer of 2017 and following a range of factual accuracy checks and the conclusion of some concerns that we raised about the way in which some judgements were made, seven of our nine core services achieved a rating of 'good' overall for the services they deliver. During the year we also received a further focused inspection of our CAMHS service in Solihull known as Solar. We were delighted to receive a 'good' rating for every domain that the service delivers as part of this inspection. Our Trust overall rating has however moved to 'requires improvement' with concerns cited in the safety domain in relation to our former approach to searching patients and also in relation to the storage of medications. As a result of these concerns, we have consulted widely on a new approach to the clinical searching of patients and our new policy which came into force on 14 May 2018 is now based on individualised risk assessments. We have also invested in new innovative technology to provide automated reporting on the temperatures of our medication fridges. This technology has an in built alarm system which will alert staff if the temperature of the fridge goes outside the recommended range. When temperatures move outside the recommended range this can impact on the clinical effectiveness of medication for our patients – so this is a very important development for us. We continue to work hard to implement our action plan arising from the inspection and hope that we will move to a rating of 'good' for the Trust when our next inspection takes place.

We have achieved some excellent accolades in recognition of the high quality of care that we deliver across our mental health services resulting in a range of accreditations which can be referred to in section three. Accreditation assures staff, service users and carers, commissioners and regulators of the quality of the service being provided. We have also worked hard to take forward our recovery model during the year and following a very successful first year when we opened our Recovery College in Birmingham, we have during 2017/18 opened a second college in Solihull.

Thank you again for taking the time to read this document. We hope that you will find this informative and that it gives you a good insight into the work we are doing to continually improve the care that we deliver.

I can confirm that to the best of my knowledge the information contained within this report is accurate

John Short, Chief Executive
Birmingham and Solihull Mental Health NHS Foundation Trust Date: 23 May 2018

Section two

This section contains:

Priorities for improvement during 2017/18

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) is committed to continuous quality improvement. This section of the report sets out the improvements we identified last year and how far these have been met, as well as the improvements we wish to achieve over the coming year.

Safe

Goal 1: To implement the positive and proactive care strategy resulting in an environment that is as safe as possible for everyone with reduced incidents of restraint, seclusion and physical assault

Why is this important?

This is an extension of the quality goal in 2016/17 which was in recognition of reducing our levels of assault to both staff and service users on the wards. Our approach to positive and proactive care in support of the national agenda has continued to be a key enabling tool to reducing incidences of violence and assault on our wards through least restrictive practice and higher levels of therapeutic engagement.

Safewards is a violence reduction model that seeks to challenge two facets of aggression management dynamics: containment and conflict. The Safewards programme is a recognised element in both the Department of Health Positive and Proactive Care agenda and the new NICE Guideline (NG:10) Violence and aggression: short term management in mental health, health and community settings (NICE, 2015).

What were the measures?

1. Reduction in the number of inpatient physical assaults on staff by 10 per cent compared to 2016/17 outturn.
2. Reduction in the number of inpatient physical assaults on patients by 10 per cent compared to 2016/17.
3. Reduction in restrictive interventions by 15 per cent in comparison with the 2016/17 outturn position.
4. Reduction in episodes of seclusion in an area not designed for seclusion by 50 per cent in comparison to the 2016/17 outturn position.

Enablers

- Implement and embed Safewards in all inpatient wards.
- Measure sanctions by the police.

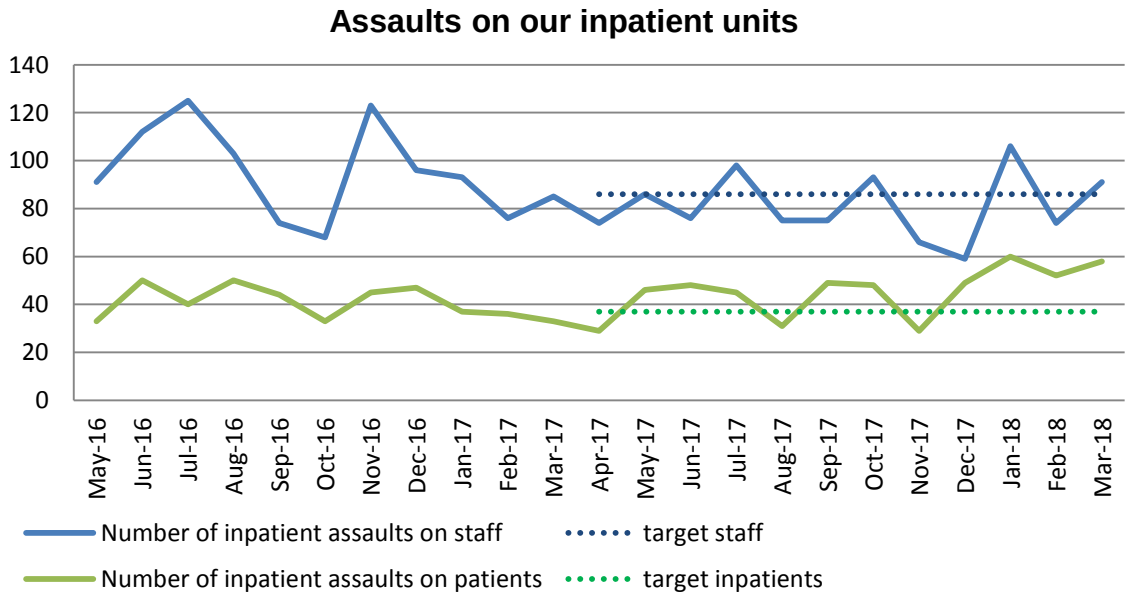
Did we achieve the goal?

Assaults on our inpatient wards

	2015/16	2016/17	Target for 2017/18	Goal Achieved?
Assaults on Staff	1,048	1,141	-10% = 1,027 for the year and 86 per month	Yes Average per month is 81 assaults
Assaults on Patients	640	488	-10% = 439 for the year and 37 per month	No Total for 2017/18 = 544
Restrictive Interventions	N/A	4,430	- 15% = 3,765.5 per month equals 313 per month	No Total for 2017/18 = 4,314
Seclusion in an area that is not a seclusion suite	N/A		Reduce by 50% We are unable to calculate the figure for 2016/17 as this was not recorded in 2015/16.	Unknown

Assaults on staff and patients

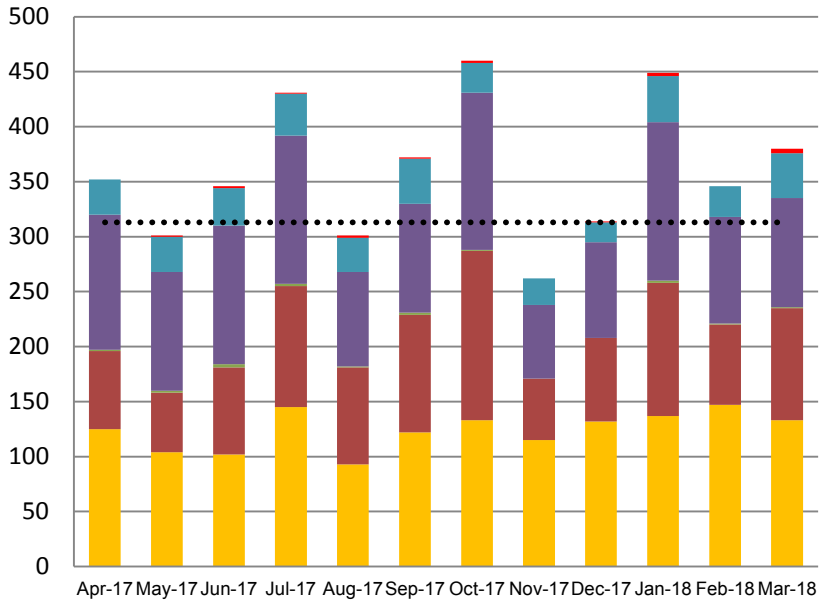
Year to date we have seen 973 incidents of physical assault on staff in our inpatient units, confirming achievement of our 10 per cent reduction target. Assaults on inpatients have slightly increased over the year and as such we are unable to achieve the target we set in our quality goal. Whilst this is disappointing, this may in part be due to the significant improvements made in 2016/17 in this area when we saw incidents of assault on patients fall by 23 per cent reduction in the year.



**in August the definition of Rapid Tranquilisation changed and these figures going forwards are now excluding oral medication*

Our target for 2017/18 was to demonstrate a reduction in the number of restrictive practices by 15 per cent, which equates to 313 a month. A restrictive intervention may be a form of physical restraint to stop them harming themselves or others and may include the use of medication or seclusion. In the year to date we seen an average of 358 restrictive practices per month. In December 2017 to February 2018 we opened three new wards; Laminar acute, Reservoir House and Adriatic ward. The majority of restrictive interventions take place on inpatient wards and therefore the introduction of these wards will have contributed to an increase in restrictive practices. However, not all of the restrictive practices can be attributed to this and we do recognise that over the year we have not seen the reduction we would have been working towards. In the Trust the oversight of restrictive practices is via our Positive and Proactive Care Expert Panel. The panel consists of multidisciplinary, experienced clinicians who work within the Trust. It also includes input from service user representatives. The panel meets monthly for one whole day. Part of its work plan includes collecting data and experiences from staff and service users, in order to develop a useful and clinical implementation strategy aimed at reducing restrictive practices and assaults on our inpatient wards.

Restrictive Interventions



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
long term segregation	0	1	2	1	2	1	2	0	1	3	0	4
seclusion	32	32	34	38	31	41	27	24	18	42	28	41
Rapid Tranq	123	108	126	135	86	99	143	67	87	144	97	99
mechanical restraint (by staff)	1	2	3	2	1	2	1	0	0	2	1	1
Prone restraints	71	54	79	110	88	107	154	56	76	121	73	102
restraint not including prone	125	104	102	145	93	122	133	115	132	137	147	133
target	313	313	313	313	313	313	313	313	313	313	313	313

The Positive and Proactive Care Expert Panel is in Year 2 of its five year plan. It continues to be a well-attended multi-disciplinary group of ten clinical staff, which has involvement of all key disciplines from most clinical areas of the organisation. Frequent contact with service users and clinical teams is ongoing, with bi-monthly meetings having teams attending the Panel to discuss their experiences.

A SeeMe worker is a regular panel member, and key issues are brought from discussions with service users regarding their experiences of restrictive practices. Service user feedback is also obtained by panel members visiting clinical areas.

A Year 1 evaluation report was presented to the Integrated Quality Committee in November 2017, including a number of qualitative and quantitative projects looking at the various work streams (such as restraint, seclusion, rapid tranquilisation, Safewards and debriefs) and a number of recommendations were made, and supported by the Committee. These are currently being implemented across the organisation, and include specific improvements such as acting upon service user feedback to develop seclusion suites, improved education and awareness of restrictive interventions for staff, changes to the electronic care records system, and improvements to the process of ensuring that debriefs for service users take place after restrictive interventions. A series of 'roadshows' were held in clinical areas, led by different panel members, to ensure that ward-based staff and service users were able to hear the feedback from their comments during the Year 1 evaluation.

In addition, a Year 2 programme of quality improvements is underway, including a number of service evaluations to delve further into how quality of care can be further improved in relation to restrictive practices, to evaluate interventions such as Safewards and positive behavioural support plans, and to gather more information regarding the experiences of staff who have been assaulted in the workplace.

Seclusion in an area that is not a seclusion suite

Target	**2016 /17**	Apr 17	May 17	Jun 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
TBC	**No data**	1	1	0	2	2	2	8	1	1	4	1	5

There have been 28 incidents of secluding patients in an area not designed for seclusions reported within the year. We are not able to compare this information with previous years as this was new data for April 2017. It is accepted that sometimes there is no option but to seclude a patient in their bedroom and we need to ensure when this happens our patients receive the care and support to ensure their physical and emotional safety during and after it has taken place. The Positive and Proactive Care Panel has been asked to look into the knowledge of inpatient staff about the practice and this has been incorporated into its work programme.

Goal 2: Our service users have reduced mortality through co-produced crisis plans, learning from mortality case note reviews and we will reduce the number of suicides

Why is this important?

Improving the mortality of mental health service users is a national priority and was the subject of further public interest and focus following the publication of the Mazars report into the investigation and reporting of deaths at Southern Health NHS Foundation Trust in December 2015.

Mortality falls into a number of categories including preventable and unpreventable death and features strongly in the Five Year Forward View for Mental Health. In December 2016, the Care Quality Commission published its report into 'Learning, candour and accountability' which made a number of national recommendations about the way in which deaths of service users are investigated.

What were the measures?

1. Reduction in the number of preventable deaths in comparison to the baseline experienced at the end of March 2016/17.
2. No inpatient suicides on our inpatient wards during 2017/18.
3. Reduction in the number of suicides of service users on our community caseload by at least 10 per cent.
4. Implementation of a report on mortality case note reviews through a defined governance mechanism by the end of June 2017 with quarterly reports to the Integrated Quality Committee and Trust Board.

Enablers

- Roll out level 2 suicide prevention training to staff.
- Implement a revised CRAM training package with 90 per cent of required colleagues completing the training.
- Improve the quality of clinical risk assessments via training, supervision and clinical audit.
- Better crisis planning for service users.
- Better quality crisis planning in community services.
- Increase the awareness of crisis support available for service users and carers.
- Implement mortality case note review.

Did we achieve the goal?

	2015/16	2016/17	Target for 2017/18	Goal achieved?
Preventable Deaths	2	3	1	Yes Total = 1 PFD
Inpatient suicides	3	2	0	No – we have had one inpatient suicide
Community suicides		24	10% reduction = 23 suicides	Yes Total = 18 suicides
Mortality reviews	n/a	n/a	To implement mortality reporting	Yes

Preventable Deaths

Target	2015/16	2016/17	Apr 17	May 17	Jun 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
1	2	3	0	0	1	0	0	0	0	0	0	0	0	0

A Prevention of Future Deaths Report (PFD) is issued by Her Majesty's Coroner if he or she believes during the inquest process that action needs to be taken by the Trust to prevent a further similar death occurring. A PFD notice was issued to G4S, Birmingham and Solihull Mental Health NHS Foundation Trust and Birmingham Community Healthcare Trust following the death of Daniel Watkins in Winson Green Prison.

A regulation 28 report to prevent future deaths was issued on 29 June 2017 following the inquest into the death of Daniel Watkins. We produced a joint response to the Coroner, NHS England and the Governor of the Prison.

The report highlighted that prison officers receive limited training on mental health conditions, with prison officers in this case being unaware of the significance of a diagnosis of unstable personality disorder. Mental health awareness forms part of the initial training for Prison Custody Officers (PCOs) at HMP Birmingham and is delivered in line with contractual obligations by G4S and BSMHFT. Since 2011 every new PCO at HMP Birmingham has received this training. Prison officers are also now offered places on a Mental Health First Aid training course, which is ran internally by the Inside Recovery and Service User Involvement Manager.

The lack of an adequate system to ensure nurses attend Assessment, Care in Custody and Teamwork (ACCT) reviews of prisoners was highlighted, as a healthcare professional was not present during the first ACCT review of Daniel Watkins contrary to guidelines. The Coroner highlighted the importance of having healthcare present during these reviews. A list of scheduled ACCT reviews is now sent to the healthcare team each day and a designated member of healthcare staff attends each review. Particular attention is given to first case reviews, which are highlighted on the daily list. Complex cases are referred to a multi-disciplinary meeting, so that the prisoner can receive enhanced mental health support where necessary. Access to additional support, for example prisoners with learning difficulties, is monitored at these meetings, and the safer custody team conducts a weekly assurance check on all open ACCT cases.

The safety of staff and prisoners was also raised as a concern. A Promoting Risk Intervention by Situational Management (PRISM) assessment of the management of violence at the prison was commissioned in July 2017, and the results will inform a full review of the establishment's violence reduction strategy, including current practices for the prevention and management of anti-social behaviour and bullying and provision for prisoners who are vulnerable. A violence reduction steering group, chaired by the Director of HMP Birmingham, was set up in June 2017. The group focuses on violence reduction in the establishment, feeding into the local violence reduction board, established in July.

An action plan, covering key areas such as bullying interventions, victim support and managing drug supply has been produced, and progress monitored at a fortnightly meeting chaired by the Director. From 1 August 2017 all incidents of violence have been investigated using a new report form. This is completed jointly by safer custody and residential staff and provided to security staff and intelligence analysts. The report form includes prompts for action to ensure: that support for victims is in place and assessment for increased vulnerability has been undertaken; that the reasons for the violence have been explored; and that any further action has been identified and taken.

Completion of these reports is monitored daily by the safer custody team and the Deputy Director. An operational meeting for wing managers is held every morning to share information about risk and to ensure that actions identified in investigations into violent incidents have been taken.

Inpatient suicides

Target	2015/16	2016/17	Apr 17	May 17	Jun 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
0	**3**	**2**	0	0	0	0	0	0	0	1	0	0	0	0

Our aim as a Trust is to continually reduce patient suicides and to eliminate suicides of patients within our inpatient wards. During the year one patient who was on leave from their inpatient unit died when she fell from a car park in Birmingham. This is a tragic case which has particularly highlighted the need for the Trust to improve its engagement and involvement of family members and carers when undertaking risk assessments and care planning alongside service users. The involvement and engagement of families and carers therefore forms a quality goal for the Trust for 2018/19.

Community suicides

	Target	2016/17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Suspected suicides		**N/A**	1	0	2	3	1	0	1	2	1	2	1	2
Confirmed suicides	**Reduce by 10% = 23**	**26**	3	1	1	3	3	2	1	0	1	3	0	0

This is a new indicator this year which focuses on suspected and actual suicide rates of patients who are in receipt of care from the Trust. We also include patients who are suspected to have died by suicide within six months of having been discharged from our care.

The initial categorisation of suspected suicide is determined by reporters and is subjective until completion of the Coroner's inquest has taken place when a verdict of the cause of death will be given. There have been 18 confirmed community suicides since April 2017. We are currently within scope for achieving our 10 per cent reduction target.

In 2017 we launched online suicide prevention training for all clinical staff. To augment this, the Nurse Consultant for suicide prevention designed a level 2 training programme for clinicians. The level 2 suicide prevention training programme was piloted in October 2016, and 10 trainers were recruited to deliver the programme, these are existing members of staff who deliver this in addition to their job. Each trainer attended STORM training, which is a nationally recognised programme developed at the University of Manchester.

The Trust training programme commenced in January 2017. Each training day provides a background of what we know about people who die by suicide, taken from both the National Confidential Inquiry and internal Trust inquiry. The focus then moves to how clinicians can apply knowledge into practice through approaches to assessing suicidality, team assessment of risk and individual practice points for change. Clinicians are able to practice these points through individual role play and group exercises. A carer with direct experience of losing someone through suicide recorded a video, which is shown and discussed as part of the training. This describes the impact on carers and opens discussion about how the service can better meet the needs of carers, and those they care for, at these vulnerable times.

We arranged 26 dates for training up to 22 March 2018. Due to resource pressures from the Home Treatment and Community Mental Health Teams involved in this pilot, attendance has been sporadic at times. Therefore additional sessions have also now been arranged in response. An evaluation is being co-ordinated by a psychology student but initial feedback is that teams are continuing to find it beneficial. Action plans continue to be generated by teams and individual members committed to provide improvement in quality and service delivery.

Mortality Surveillance

The Mortality Surveillance process is now in place and a Mortality Dashboard is live. We are now publishing quarterly reports on our mortality levels. We have also published our Learning from Deaths (LFD) Policy on our website.

The national guidance for LFD (National Quality Board reference) states that '*as a minimum and from the outset, Trusts should focus reviews on inpatient deaths' and 'In particular contexts, and as these processes become more established, Trusts should include cases of people who had been an inpatient but had died within 30 days of leaving hospital'.*

Within BSMHFT, we have decided to go beyond these minimum requirements, and to not only include inpatients but also to review the care of active patients on our community caseload and those patients who have died within six months of discharge from our services. Whilst this means that potentially our figures will seem higher than those reported in other organisations, we believe that it is important to take advantage of all learning opportunities, so that we can ensure that we are working towards providing the safest services possible. As a result of this process we have clinically triaged 719 of the 774 deaths reported via our incident reporting system during the year.

The triage process identified that 62 of the deaths required a Mortality Casenote Review and 35 of the deaths required a Serious Incident Root Cause Analysis investigation. Of these, eight of the deaths were identified as probably avoidable.

Within the eight deaths associated with a problem with care, there are some emerging themes that we need to act upon in 2018/19 to ensure that we learn from these cases in the future. These include improved family and carer involvement and engagement, increased use of longitudinal risk assessment and increased recognition of suicidal risk factors when conducting risk assessments, care plans and crisis plans. These all feature within aspects of our quality goals for the Trust for 2018/19.

Goal 3: NEW – To reduce the number of incidents resulting in harm to our service users

Why is this important?

Incident reporting theory suggests that organisations with robust risk culture will still report high levels of incidents but that these incidents will have a low impact. So it is important for us to measure incidents to see what is happening on our wards and within our community settings in conjunction with the impact they have on our service users.

What were the measures?

Quarterly reports on harm levels associated with incidents were presented to the Integrated Quality Committee.

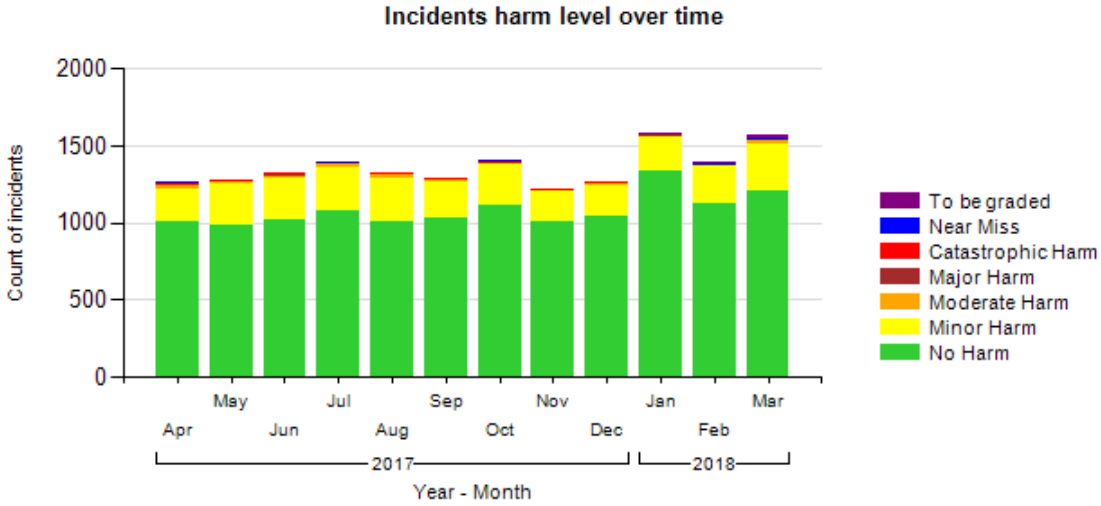
Enablers

- Implement a self-harm reduction programme.
- Implement the suicide prevention programme.
- Implement the positive and proactive care programme.
- Implement the clinical risk management policy and associated training.

Did we achieve the goal?

	Performance in 2016/17	Target for 2017/18	Goal Achieved?
Preventable Deaths	N/A this is a new process	4 quarterly reports presented to the IQC	Yes

Latest National Reporting and Learning System data (up to end of September 2017) demonstrates that we have a lower number of incidents resulting in harm that the average seen in other mental health trusts in the country. The national benchmarked data states that levels of harm caused to patients occur in approximately 35 per cent of incidents reported across the country. The table below demonstrates that in our Trust we are typically seeing levels of harm occurring in 23 per cent of incidents reported. More recently we have seen harm levels reduced to as low as 18.5 per cent.



The above graph shows the ratio of harm to no harm in our incidents reported on our Trust system across the year.

Goal 4: We will have a strong and safe approach to the management of leave for detained service users with a reduction in the number of detained patients who fail to return from section 17 leave

Why is this important?

When service users are detained under the Mental Health Act and require inpatient care it is our responsibility to ensure that the physical, relational and procedural security that we have in place protects the safety of them and of others. If a service user absconds from an inpatient unit (leaves the unit without the authorisation of the Trust that they are safe to do so) the risk to themselves and to others increases. In 2016/17 we successfully achieved our goal of reducing absconsions from inpatient units and now we need to do the same for our incidents of service users who fail to return from section 17 leave.

What were the measures?

- A reduction of 20 per cent in the number of detained patients who fail to return from section 17 leave.

Enablers

- Effective and timely risk assessment pre leave
- Post leave evaluations

Did we achieve the goal?

Leave is a key therapeutic intervention that is utilised within all inpatient services. It must be managed so that it is a safe and positive experience for the patient and others. All leave may involve an element of risk.

The prescription of leave requires an assessment and identification of the risks involved and an assessment of arrangements which can best ensure a safe and successful outcome. In 2016 the Trust revised its leave arrangements including the forms and policy.

This took a few months to become embedded and by September 2017 we can see that the form was consistently used. This is the first time we have been able to capture the total number of section 17 leaves facilitated throughout the Trust. What is very noticeable is that the proportion of failure to return from leave is a fraction of the total leaves facilitated ranging from 0.4 per cent to 0.8 per cent. The percentage of individuals recorded as failing to return from leave in 2016/17 was 1.5 per cent. During 2017/18 this reduced to 0.54 per cent representing achievement of our 20 per cent reduction target.

	Total number of leaves	Failure to return from section 17 leave	Proportion of failure to return from leaves
Mar-18	3,242	17	0.5%
Feb-18	3,172	13	0.4%
Jan-18	3,342	22	0.7%
Dec-17	3,154	16	0.5%
Nov-17	3,977	17	0.4%
Oct-17	4,199	17	0.4%
Sep-17	4,045	27	0.7%
Aug-17	4,188	21	0.5%
Jul-17	4,062	32	0.8%
Jun-17	3,591	16	0.4%
May-17	3,514	23	0.7%
Apr-17	3,549	16	0.5%
Mar-17	3,599	16	0.4%
Feb-17	3,256	23	0.7%
Jan-17	3,333	16	0.5%
Dec-16	3,251	18	0.6%
Nov-16	3,603	10	0.3%
Oct-16	3,957	10	0.3%
Sep-16	3,596	13	0.4%
Aug-16	2,617	18	0.7%
Jul-16	1,500	18	1.2%
Jun-16	897	16	1.8%
May-16	736	21	2.9%
Apr-16	180	15	8.3%

Caring

Goal 5: To achieve improvements in patient experience scores in the National Community Mental Health Survey

Why is this important?

Ensuring that service users, their families and their carers feel engaged and involved in their care and treatment plan is a fundamental aspect of the ‘triangle of care’ and is an important aspect of recovery.

We know from our National Community Mental Health Service User Survey that we do really well in some aspects of this, however results show us that we have improvements to make in relation to crisis care in particular, together with ensuring that service users always know who is in charge of their care and that if we make changes to the team, this does not impact negatively on the care an individual is receiving.

What were the measures?

- National Community Patient Survey results.

Enablers

- Better crisis planning for service users.
- Better quality crisis planning in community services.
- Increase the awareness of crisis support available for service users and carers.
- Ensure that patients, carers and families recognise and understand crisis plans.

Did we achieve the goal?

	Goal achieved?
To achieve improvements in patient experience scores in the National Community Mental Health Survey	No

The results for the National Patient Survey for Community Mental Health were published on 15 November 2017. Our overall experience score is shown below with our scores for crisis care.

There are a range of initiatives underway to improve in the identified areas and the results of the patient survey in general. These include:

1. A review of our care planning process through a project called the Clinical Development Programme. This is a novel project where the work is being driven by three clinical teams, to identify what they perceive stands in the way of delivering excellent care and supporting initiatives to remove these barriers.

The project is in its infancy, they have had five workshops to identify the barriers, prioritise them, investigate solutions and confirm that the proposed solutions match the identified problems. The next stage will be more difficult, actually removing the barriers to delivering quality care.

2. Better information in the community team hubs. Each hub has been made responsible for displaying information and giving it to service users, carers and families. A briefing session has been held with all administration leads to outline the standards and processes. During these sessions the admin leads proposed a simple two sided leaflet be produced to be handed to all service users and their carers for February to May 2018. This leaflet offers a variety of support organisations for issues which may affect our service users' lives but we are unable to support such as debt, housing, welfare benefits and social activities. The effectiveness of this approach will be evaluated at the end of the patient survey collection period.

3. Observe and Act. We have always had mystery shoppers with the Trust, however the Observe and Act version of mystery shopping reviews in more depth and encompasses actions in the process. The training was launched in January 2018 and we are piloting this in Orsborn House. One of our SeeMe workers, along with volunteers, visits the hubs, and carries out an inspection for quality of information, the waiting area and cleanliness. They also arrange to sit in on three clinical appointments to measure the quality of care given by the clinicians, with the patient's consent. We will be evaluating this methodology for a full launch later in the year.

4. Building stronger and more partnerships (eg with Mind, Better Pathways, local authorities, APM) to ensure more support for physical health, financial advice and employment is available. This includes partnerships with employment advisors to increase employment opportunities.

The 2018 patient survey was distributed in February so we may not see the fruits of this work in the results but hope we are on a path of improving the patient experience and that over time we will see an improvement in our community survey results.

Goal 6: NEW - Families and carers have a positive experience and feel involved in and supported by our services

Why is this important?

Families and carers are the main support for our service users and they are key to enabling recovery and staying well. We need to ensure they are supported in providing this role and where appropriate informed of all the things they need to know to help themselves and the service user remain well and access support in a crisis. The Parliamentary Health Service Ombudsman (PHSO) investigated a complaint from a family where we did not support them as we should have. We need to assure ourselves that families are being involved in the care of service users and we are supporting them to carry out their essential role.

What were the measures?

1. Development of a Recovery College spoke in Solihull, thereby widening access to one of our main vehicles to disseminate good practice around recovery.
2. Accreditation of Recovery College through ImROC (Implementing Recovery through Organisational Change).
3. All service users encouraged to identify a carer or family member and proactively including them in care planning.

Enablers

- Identification of carers on RiO record.
- Co-production of care plans.

Did we achieve the goal?

	Goal Achieved?
Develop Recovery College spoke in Solihull, thereby widening access to one of our main vehicles to disseminate good practice around recovery.	Yes
Accreditation of Recovery College through ImROC.	Initial feedback from the accreditation visit is very positive
All service users are encouraged to identify a carer or family member and we proactively include them in care planning.	Ongoing

The Recovery College in Solihull has started and has proven successful particularly in the second term with a more accessible building and location. We will shortly commence a third term at Solihull Renewal Centre. We are seeking a location in the north of the city, a shortlist has been drawn up of potential sites and the summer term will include an Erdington centre.

We continue to develop new courses and aim for two new courses per term in addition to amendments to the programme to keep the prospectus fresh and exciting. The Recovery College continues to evaluate well in feedback and we are very proud of its success.

ImROC visited the college in December 2017 for an accreditation visit and early indication suggests they were impressed with the arrangements to plan, support and administer the sessions. We await further feedback from them which will support the ongoing development of the College.

The Carers Assessment project started this year. The group consists of carers, clinical staff and support service staff. One of the outputs to date has been a Trust carer's assessment, which is now live on RiO (our patient information system). In addition we have constructed an introductory letter to give to all carers if they attend appointments or be sent to their homes, identifying what team is looking after the service user and who is the main contact for the service user and what the carer should do if they have questions or want to talk to someone.

This letter went live in RiO in March 2018. A further stream of work is developing improved interventions with carers. A recent innovation was the 'Planning for the Future' booklet which is a detailed guide to planning care for a loved one when the carer may not be around.

Comparison to performance in 2016/17 is not possible as this work was new in 2017/18.

Effective

Goal 7: To implement our Physical Health Strategy

Why is this important?

People with severe mental illness die on average 15-20 years earlier than other people. This is thought to be due to a number of factors including potentially modifiable health-risk behaviours, such as smoking, alcohol and addictions, lack of exercise, obesity and social factors such as poverty, homelessness, and unemployment.

The medication we prescribe in secondary mental health services may contribute to this further with increased appetite, lipid abnormalities and glucose dysregulation.

We have made some achievements over the years in ensuring we are aware of our service users' physical health needs but this requires further improvement. To support this we need better monitoring at service user level and team level.

The number of service users whose fall resulted in serious harm did reduce in 2016/17 as has the total number of falls but we would like to improve this further this year.

What were the measures?

1. Every inpatient to have completed cardio metabolic indicators on RiO (our electronic patient record system).
2. Every community patient with a diagnosis of psychosis to have completed cardio metabolic risk factors on RiO that are reviewed annually.
3. Every service user across inpatient and community services to have a completed Lifestyle risk assessment on RiO.
4. Reduction in the number of incidents of falls in our inpatient units by 15 per cent in comparison to the 31 March 2017 outturn position
5. The elimination of avoidable falls resulting in serious harm.

Enablers

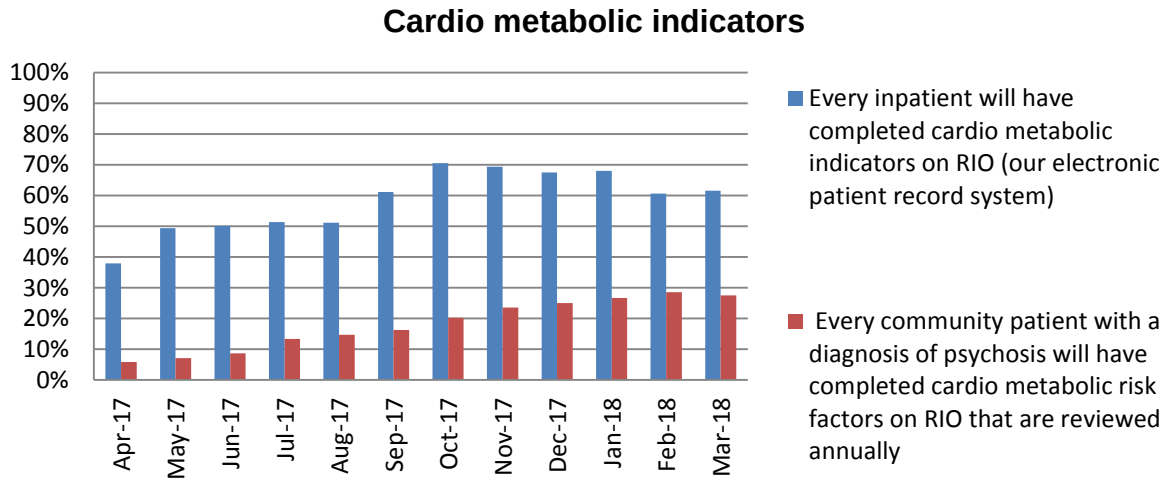
- Ensure that training in falls prevention and management is delivered to targeted services such as Older Adults where falls prevalence is much higher.
- Implement the Falls Prevention and Management Policy.

Did we achieve the goal?

	2016/ 17	Target for 2017/18	Goal Achieved?
Every inpatient will have cardio metabolic indicators	n/a	100%	No Total = 61.5%
Every community patient with diagnosis of psychosis will have cardio metabolic indicators	n/a	100%	No Total = 27.5%
Every service user will have a completed rethink form	n/a	100%	No This report is not available
Reduce the incidents of falls on inpatient units	358	-15% = 304 for the year and 25.3 per month	No Total = 547
Eliminate avoidable falls resulting in serious harm	5	0	No Total = 2

Physical health monitoring

In conjunction with the information development team, the Physical Health Committee has been developing routine reports to help monitor our progress with undertaking our responsibilities for monitoring the physical health of our service users.



Our initial focus was on completion of the core cardio metabolic indicators; smoking, alcohol consumption, glucose levels, BMI, blood pressure and lipids. At the beginning of 2017 RiO (our electronic patient record) was altered to ensure we could record this information in a way that could be monitored. Several reports were developed enabling clinicians to see their own recording results and those of others.

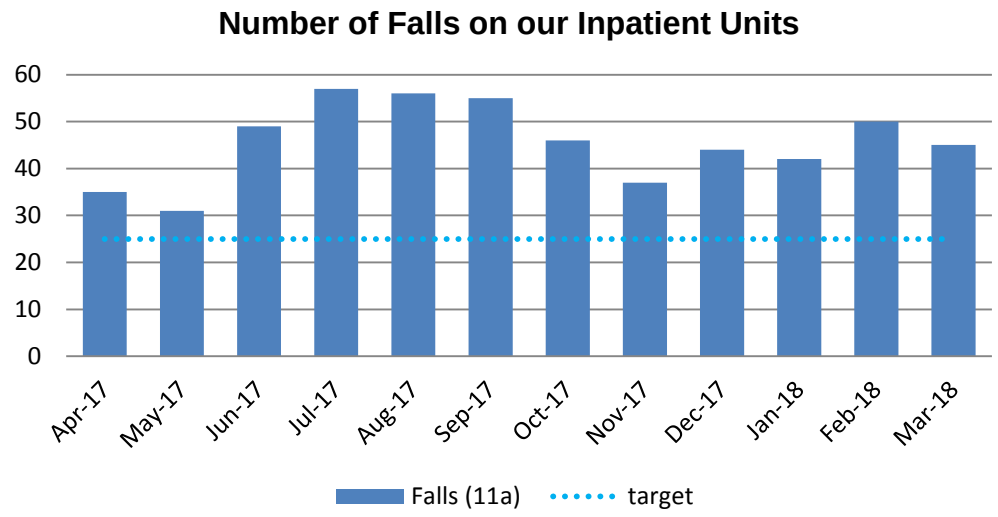
It is equally important to ensure staff are equipped to respond to the findings of physical health monitoring and our Nurse Lead for Physical Health has been visiting wards and community teams to ensure they all know what is required, refresh any skills, educate on what should be done when a patient is found to have certain conditions and show people exactly what need to be recorded and where.

The Lead Nurse for Physical Health has re-established the process for identifying a Physical Health Link worker for each team. Training events are being held quarterly and email communication routinely sent out to keep the link workers engaged and increase their knowledge. Feedback has been really positive and the last event, which included an alcohol awareness session run by our COMPASS team, there was standing room only.
So whilst we have not achieved the incredibly difficult target of 100 per cent, our performance over the year has increased by 24 per cent on inpatient wards and 22 per cent in community services, which is an improvement we are proud of.

Our goal of ensuring that every patient has a rethink lifestyle physical health tool completed has not been achieved this year. This is due to a number of developmental and formatting issues. These have now been resolved and the tool will be launched during Quarter 1 of 2018/19.

Falls
During the year we have seen a reduction in the number of falls of patients on our Dementia and Frailty Wards which demonstrates the hard work that has been taken forward in relation to falls prevention and management within this vulnerable group. We have however seen an increase in falls occurring in our adult acute wards, demonstrating the need for the Trust to further invest in falls prevention and management skills, knowledge and practice for this cohort of patients. In totality, the number of falls in the Trust has therefore increased. As such we are taking forward a focused piece of work to ensure that during 2018/19 our expertise in falls prevention and management is shared across the Trust.

The work streams have been established and are in the early stages of implementation.



*Following a data quality exercise we identified that previous category of Falls also included slips and trips (not resulting in a Fall). We have therefore cleansed this data as far back as April 2016 and now present information that purely relates to Falls of patients within out care.

Falls resulting in serious harm

2015/16	2016/17	Apr 17	May 17	Jun 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
10	**5**	1	0	0	0	0	0	0	0	1	0	0	0

We have reduced the numbers of falls that resulted in serious harm from 10 in 2015/16, to five in 2016/17 to two in 2017/18, demonstrating a 50 per cent reduction year on year which is highly commendable. Sadly, we did not fully eliminate falls resulting in serious harm, however this will form part of the work of the Falls Prevention and Management Group who are reviewing all serious incidents that relate to falls and this will include the two falls reported this year. They will look to identify whether the reviews undertaken have fully explored root causes for the falls and if not to further identify any root causes which have not been identified.

In addition to the above the QI group will examine whether Trust policy and practice has been robustly tested and also whether Trust policy and practice has been tested against national practice and guidance. The group will review clinical processes in place to manage falls and the risk of falls and the review of training that is in place in the Trust for staff in falls prevention and management, including consideration of the physical environment and the equipment available.

Responsive

Goal 8: Improve communication with GPs to ensure timely information exchange

Why is this important?

It is important that we have timely and accurate communication with our primary care colleagues to ensure that our patients receive a continuous and co-ordinated service across both primary and secondary care. We need to ensure that we write to our service users' GPs following critical points in the pathway.

What were the measures?

1. Letters to GPs following CPA reviews and routine outpatient appointments sent within two weeks.
2. Discharge summaries from inpatient stay and home treatment team episodes sent within 48 hours and a detailed summary within one week.

Did we achieve the goal?

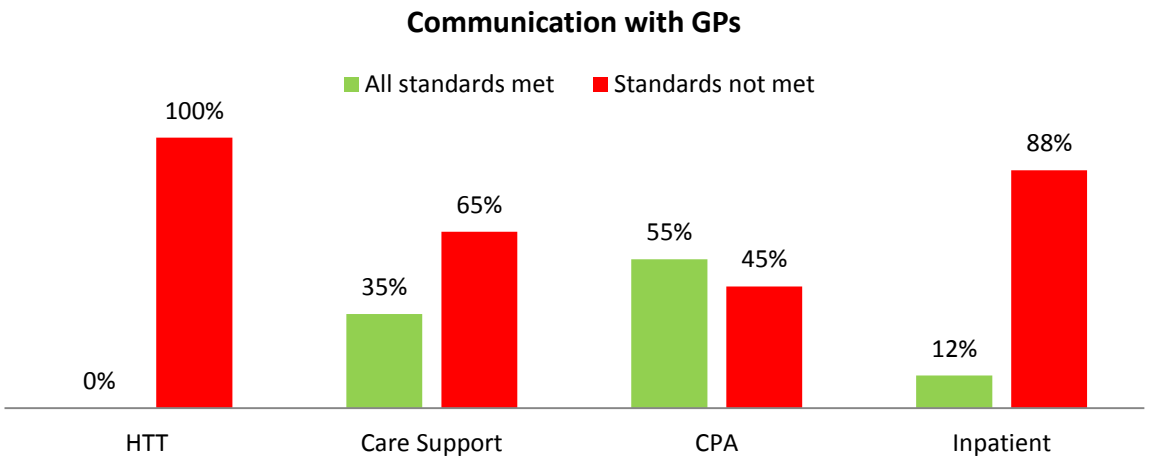
	Target for 2017/18	Goal achieved?
Ensuring letters to GPs following CPA reviews and routine outpatient appointments are sent within 2 weeks	**90%**	No Results from February 2018 audit indicate a rate of 55% for patients on CPA and 35% for patients on care support.
Discharge summaries from inpatient stay and home treatment team episodes are sent within 48 hours and a detailed summary within one week.	**90%**	No Results from February 2018 audit indicate a rate of 12% compliance of inpatient discharge and 0% of discharge from HTTs

Standards for communication to GPs

Letters to GPs need to be sent within 48 hours when discharged from an inpatient unit or Home Treatment Team and within two weeks of an outpatient appointment for both CPA and Care Support. The letter needs to contain the following information:

- NHS number
- all primary and secondary mental health diagnoses
- medications prescribed and recommendations (including duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication)
- ongoing monitoring and/or treatment needs for cardio-metabolic risk factors identified, as per the Lester Tool
- care plan or discharge plan.

An initial audit was carried out in May 2017. The re-audit was carried out in February 2018 using discharges and appointments from November 2017. Closer inspection of the data shows that letter contains the information required but the timeliness of the letters is causing us to miss the target.



Well Led

Goal 9: To develop and embed a system of integrated reporting

Why is this important?

Moving to a system of integrated reporting will mean that quality outcomes are able to be considered alongside issues such as workforce challenges, financial challenges and our performance against national waiting time and access standards. During the year we will scope the requirements and needs of the system, finalise the specification and secure funding. We aim to go out to tender on the system before the end of the year. This will culminate in the development of an 'integrated dashboard' which will enable us to see 'at a glance' whether any of the challenges described above are having an impact on quality, safety, effectiveness and experience of care. We will develop the integrated dashboard at Trustwide level and at more granular levels so that each service area can clearly see how it is contributing to the Trustwide picture and how we can then work together to celebrate and share successful performance whilst also taking action to remedy shortfalls. This is an important part of our approach to improved governance.

What were the measures?

- We measured our performance with this goals by reviewing the progress against the key milestones below:
  - Explore market opportunities for integrated reporting by end September 2017.
  - Confirm specification for integrated reporting system and secure business case approval by end December 2017.
  - Place specification out to tender January 2018.

Enablers

- Development of an information strategy which incorporates the need for integrated reporting.
- Establish a stakeholder project group to explore market opportunities and develop specification.
- Secure funding for an integrated reporting solution.

Did we achieve the goal?

The Executive Director of Finance has commenced discussions within the Trust about the shape and functionality required of the integrated reporting solution and has also reviewed systems in place in some of the trusts which have been awarded 'outstanding' ratings by the Care Quality Commission. In support of a movement towards integrated reporting, the Trust is investing in an Electronic Document Records Management System (EDRMS), which will allow full access and categorisation of all our electronic data across all our systems. We are in the final stage of an associated tender process and have selected our supplier. EDRMS will enable true integrated performance reporting. As EDRMS is a strategic development, the Executive Director of Finance is in the early stages of building an interim solution to integrated reporting. An early draft was available in April 2018 and this is now being consulted on with various committees and staff across the Trust.

With reference to business intelligence software, the information department has evaluated the two market leaders and is creating an options paper based on their analysis. This options paper will be a forerunner to any required business case prior to any tender / purchase of the business intelligence software.

Goal 10: Further develop the Quality Improvement Framework

Why is this important?

Whilst the Trust delivers many examples of quality improvement, there is no single quality improvement methodology or approach used consistently across the organisation. Our aim therefore is to develop a single quality improvement framework which outlines the approaches, tools and techniques, underpinned by robust quality improvement and other methodologies that experience has shown to be most successful in delivering improved quality alongside better value. Adopting such a framework should deliver:

- simplified and standardised clinical packages of care
- improved service user experience and effectiveness
- increased compliance and consistency with regulatory requirements
- greater opportunities for sharing good practice, skills and expertise
- improved quality of service and support to staff
- enhanced management information and improved reporting tools
- cost efficiency through economies of scale.

What were the measures?

- Completion of a review of the Trust's approach to quality improvement and comparison with best practice models by the end of July 2017.
- Development of a best practice framework for quality improvement and gain approval to this framework by the end of September 2017.
- Implementation of the revised framework by the end of December 2017.

Enablers

- Development of an information strategy which incorporates the need for integrated reporting.
- Establish a stakeholder project group to explore market opportunities and develop specification.
- Secure funding for an integrated reporting solution.

Did we achieve the goal?

During the year the Trust achieved approval to a business case for an external partner in quality improvement and deployed a competitive tendering process. Following this a partner was appointed in April 2018.

An information strategy has been developed and is now in place within the Trust.

Our quality priorities for 2018/19

Our quality priorities for 2018/19 have been the subject of consultation with senior clinicians across the Trust, via the Trust Clinical Governance Committee and the Integrated Quality Committee with open attendance for the meeting. They have also been the subject of consultation with the Council of Governors.

In March 2017 our Trust Board approved the Quality Strategy for the Trust for the period 2017 to 2020.

Our quality priorities for year two of the implementation of this strategy are detailed below.

Goal 1: Develop and implement a clinically driven and consistent approach to quality improvement across the organisation

Measures of success

- Appointment of an external partner with expertise in quality improvement.
- Leadership capacity and capability will be in place in quality improvement methodologies and delivery.
- Broader workforce capacity and capability will be in place in quality improvement methodologies and delivery.

Enablers

- Engagement, training and skills development of staff in quality improvement.
- Identification and agreement of priorities and focus through a diagnostic process.

How will this goal be monitored, measured and reported on?

Progress will be reported on a monthly basis in our Quality Report which is submitted to the Trust Clinical Governance Committee, the Integrated Quality Committee and the Trust Board.

Goal 2: Provide services which ensure that mental health and physical healthcare needs are assessed and given equality of consideration when developing, planning and delivering care

Measures of success

- Reduce falls across our inpatient services by 15 per cent compared to 2016/17 outturn.
- To reduce falls that result in significant harm by 50 per cent compared to 2017/18.
- Increase cardio metabolic assessment of inpatients and community patients with a diagnosis of psychoses to achieve the 90 per cent of inpatients and Early Intervention patients and 75 per cent for community patients on the Care Programme Approach (CPA).

Enablers

- End to end review of falls prevention and management and consistent implementation of best practice across all inpatient sites.

- Setting up and capturing data that indicates the number of service users who smoke within our inpatient services, the number of whom actively take up nicotine replacement therapy (NRT) during an inpatient stay, and the number of service users who are assessed as being successful in quitting smoking and/or remain engaged with NRT at discharge
- An increase in the number of service users who access e-cigarettes as an alternative to tobacco with/or without NRT as an adjunct.
- Develop and implement equitable provision of physical activities across adult wards and Steps to Recovery.

How will this goal be monitored and reported on?

Progress will be reported on a monthly basis in our Quality Report which is submitted to the Trust Clinical Governance Committee, the Integrated Quality Committee and the Trust Board.

Goal 3: Service users have reduced mortality through co-produced crisis plans, learning from mortality case note reviews and we will reduce the number of suicides

Measures of success

- Reduce number of confirmed suicides of patients on our caseload representing a 20 per cent reduction compared to 2016/17.
- No inpatient suicides on inpatients wards.
- No never events.
- Improvement in crisis plan measurement in patient survey (Q21 and Q23) 'Do you know who to contact out of hours if you have a crisis?' and 'When you tried to contact them did you get the help you needed?'

Enablers

- Themes and learning points from Learning from Deaths.
- Improved family and carer engagement in care planning, crisis planning and learning from serious incidents and mortality.
- Ensure all clinical staff have received suicide prevention training.
- Evaluate the opportunity to implement three day post discharge follow up and ensure a care plan is in place at the point of inpatient discharge.

How will this goal be monitored and reported on?

Progress will be reported on a monthly basis in our Quality Report which is submitted to the Trust Clinical Governance Committee, the Integrated Quality Committee and the Trust Board.

Goal 4 - Embed a culture of least restrictive practice with reduced incidents of prone restraint, seclusion and physical assault

Measures of Success

- Reduce inpatient physical assaults on staff by 20 per cent compared to 2016/17 outturn.
- Reduce inpatient physical assaults on patients by 12 per cent compared to 2016/17.
- Ensure compliance with environmental and clinical standards relating to seclusion.
- Reduce incidents of prone restraint by 15 per cent compared to the 2016/17 outturn position.

Enablers

- Increase the use of post incident review forms to 100 per cent by October 2018.
- Further embed Safewards in all inpatient areas in conjunction with Positive Behavioural Support principles.
- Review of seclusion policy and increase in training for all staff including medical staff.
- Learn from service user feedback to improve the seclusion environment.
- Environmental works to take place to ensure all seclusion suites meet national standards.
- Review by Estates and Facilities department of all seclusion suites and long term segregation facilities to ensure all equipment is fully functioning.
- Systemise the use of Advanced Statements on all Psychiatric Intensive Care Units (PICUs).

How will this goal be monitored and reported on?

Progress will be reported on a monthly basis in our Quality Report which is submitted to the Trust Clinical Governance Committee, the Integrated Quality Committee and the Trust Board.

Goal 5: Promoting recovery, co-production and family, carer and service user involvement

Measures of success

Improvement in Q37 of the National Community Mental Health Service Users Survey Results: 'Have mental health services involved a member of your family or someone else close to you as much as you would like?'

Enablers

- Extension of the Recovery College model to the north of the city of Birmingham.
- Scope all opportunities (existing and future) for co-production and family, carer and service user involvement from ward to board.
- Roll out of the family and carer pathway pilot programme including signposting for carers and carers' assessments.
- Evaluate the learning from the employment experience of peer support workers and establish next steps for sustainability.

How will this goal be monitored and reported on?
Progress will be reported on a monthly basis in our Quality Report which is submitted to the Trust Clinical Governance Committee, the Integrated Quality Committee and the Trust Board.

Statements of assurance from the Board

During 2017/18, Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) provided and/or sub-contracted 11 relevant health services.

BSMHFT has reviewed all the data available to them on the quality of care in 11 of these relevant health services.

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

The relevant health services provided by the Trust are in the following areas:

- Acute Mental Health
- Adult Community Mental Health
- Offender Health
- Older Adults Mental Health Services
- Psychiatric Intensive Care
- Psychological Services (IAPT)
- Secure Mental Health Services (Men's Low and Medium Secure, Women's Medium Secure and Forensic CAMHS)
- Specialty Mental Health Services (Perinatal, Deaf Services, Eating Disorders, Inpatient CAMHS and Neuropsychiatry)
- Substance Misuse Services
- Urgent Care/Crisis Care
- Youth Community Mental Health Services

Participation in national quality improvement programmes

During 2017/18, 5 national clinical audits and 1 national confidential inquiry covered relevant health services that Birmingham and Solihull Mental Health NHS Foundation Trust provides.

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

The national clinical audits and national confidential inquiries that Birmingham and Solihull Mental Health NHS Foundation Trust was eligible to participate in during 2017/18 are as follows:

- National Confidential Audit into Suicide and Homicide by People with Mental Illness: Annual Report 2017 (NCISH).
- Early Intervention in Psychosis Audit (AEIP)
- National Clinical Audit of Psychosis (NCAP)
- Prescribing Observatory for Mental Health (POMH)
  - Prescribing High Dose and Combined Antipsychotics (1g & 3d)
  - Use of Depot/Long-acting antipsychotic injections for Relapse Prevention (17a)
  - Prescribing Valproate for Bipolar Disorder (15b)

The national clinical audits and national confidential inquiries that Birmingham and Solihull Mental Health NHS Foundation Trust was eligible to participate in and participated in, and for which data collection was completed during 2017/18 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or inquiry.

National clinical audits and confidential inquiries

Title of National Clinical Audit	Eligible	Participated	% *
National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	Yes	Yes	Unavailable
Early Intervention in Psychosis Network (EIPN)	Yes	Yes	100% (87 patients)
National Clinical Audit of Psychosis (NCAP)	Yes	Yes	100% (100 patients)
Prescribing High Dose and Combined Antipsychotics (1g & 3d)	Yes	Yes	353[1]
Use of Depot/Long-acting antipsychotic injections for Relapse Prevention (17a)	Yes	Yes	181[1]
Prescribing Valproate for Bipolar Disorder (15b)	Yes	Yes	97[1]

** percentage of required number of cases submitted*

[1] POMH do not provide ascertainment rates. The figures provided are the number of cases submitted by Birmingham and Solihull Mental Health NHS Foundation Trust

The reports of 4 national clinical audits were reviewed by the provider in 2017/18 and Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

POMH topic 1g & 3d Prescribing High Dose and Combined Antipsychotics

For this audit we gathered data from a significant sample – 353 patients from 34 clinical teams.

Every patient in our sample who was prescribed regular high-dose antipsychotics (not including the medications which have been prescribed on an 'as needed' basis) had their blood pressure, pulse, temperature and body weight checked in the past year. In addition, 98 per cent of these patients had also had an ECG carried out in the last year. This is compared to 83 per cent of the National Sample.

We did find that when 'as needed' medication was taken into consideration, that just over half of our Acute and Psychiatric Intensive Care Unit patients were being prescribed a total daily dose of antipsychotics that was higher than BNF limits. Similarly, 62 per cent of the patients in our sample were being given a combination of antipsychotic drugs when 'as needed' medication was taken into account (compared to only 9 per cent when 'as needed' medication was not taken into account).

The audit also highlighted that we are not always including statements in care plans when we are prescribing high-dose antipsychotics to our patients. This was found to be the case for all of the Acute and Psychiatric Intensive Care patients included in our sample.

With this in mind, we agreed on these key actions:

- Through the use of appreciative enquiry, we need to explore the reasons why clinicians (particularly in our Acute Care and Psychiatric Intensive Care settings) are prescribing antipsychotics on an 'as needed' basis.
- The template on our electronic prescribing system for 'as needed' antipsychotics has been reviewed. It now emphasises the need for a stop date so that prescriptions for 'as needed' antipsychotics are only valid for a limited time. Early anecdotal feedback suggests that the move has encouraged some review of 'as needed' antipsychotic prescribing.
- Work with Clinical Directors and Consultant Psychiatrists to ensure that ward rounds include specific discussions of antipsychotic medications. This will hopefully help ensure that our patients on high dose antipsychotics have a clear plan for regular clinical review.

POMH topic 17a Use of Depot/Long-acting antipsychotic injections for Relapse Prevention

For this audit we gathered data from 181 patients, from 25 clinical teams within our Trust. We found documented evidence for 76 per cent of the patients included in the sample that they had been involved in the generation of their own care plan. This figure is only slightly less than that found for the total national sample (80 per cent). The audit also highlighted how as a Trust, we are regularly documenting a patient's relapse signs and signatures in their care plan.

We scored better than the total national sample against this standard – 83 per cent compared to the 73 per cent. Another area where we scored well was in relation to the inclusion of a crisis plan in a patients care plan – 99 per cent of the patients included in our sample had one (compared to 82 per cent for the total national sample).

Where we did less well was in having a clinical plan within a patients care plan for when they either fail to attend an appointment for their depot, or when they decline their depot. Although for 78 per cent of our patients this information was available elsewhere (such as in local service or team protocol), it was only available in the actual care plan for 22 per cent of our patients.

With this in mind, it was agreed that a key action would be:

- That the Pharmaceutical Therapies Committee will produce a model care plan template which will include the rational for initiating depot and what to do if a patient defaults from this.

POMH topic 16a Rapid Tranquilisation

For this audit we gathered data from 89 episodes of rapid tranquilisation that occurred across 22 different teams within our Trust.

The results of this audit showed that as a trust, we do not always document whether we have had a prompt debrief (within 72 hours) following an episode of rapid tranquilisation. We could only find documented evidence that a prompt debrief occurred in 11 per cent of our sample, compared to 52 per cent in the total national sample.

Further to this, the audit showed that as a Trust we do not always update patients care plans following episodes of rapid tranquilisation. The standards state that updates to care plans should occur within a week of the rapid tranquilisation incident occurring. Updates to care plans should acknowledge patient preferences and include details of how any future episodes of rapid tranquilisation will be managed. Only 20 per cent of the patients in our sample had their care plan updated with details of how any future episodes of acutely-disturbed behaviour might be managed, and only 8 per cent of our sample had documented evidence that patient preferences had been acknowledged.

A significant finding from this audit was around heart monitoring when administering certain rapid tranquilisation drugs. The standard states that if evidence of heart monitoring within the last year is absent, injections of a drug called Haloperidol should not be given to patients. There were 6 patients in our sample who had been given Haloperidol and only half of these had documented evidence of heart monitoring within the last year.

With this in mind, we agreed on this key action:

- We reviewed the location of every heart monitoring machine we had in the Trust and found that there were a few sites that did not have easy access to one. In response to this, machines were moved around and three more machines were purchased to bridge the gaps that were identified, thus ensuring that all sites have easy access to heart monitoring machines.

- We agreed to use the successful work with the use of a digital device for clinicians to use to carry out therapeutic observations to see if an additional element could be built for physical observations. To do this a few changes are required to RiO, but once implemented we can pilot the idea on a ward to see if this idea works and improves the carrying out of physical observations following an episode of rapid tranquilisation. A proof of concept paper has been written by our project team and the pilot should start early in Quarter 1 on Hibiscus ward.

National confidential inquiry (NCI) into suicide and homicide

The NCI published their Annual Report in October 2017. The report shows that the lowest rate of suicide in the Country is 7.4 per 100,000 in Hertfordshire and West Essex, the highest is Cornwall and Isles of Scilly at 14.4. Birmingham and Solihull have a rate of 9.2 per 100,000. The NCI have published a safety toolkit containing key findings that can reduce suicide levels. We have assessed ourselves against this toolkit and can see that we are largely compliant with the recommendations. Findings include:

- Good compliance with removal of ligature points. Good compliance with ligature risk assessments. Pilot proposed for ligature free bedroom door on a Psychiatric Intensive Care Unit in May 2018.
- Good progress with reducing absconding - levels have reduced by over 50 per cent during the last two years.
- Post inpatient discharge follow up – The assessment identified some challenges in achieving effective qualitative three day post discharge follow up and this is therefore now forming part of the enablers to our quality goal to reduce suicides during 2018/19.

Care planning at the point of inpatient discharge – whilst we are compliant with this measure, serious incident findings do demonstrate that the quality of care plans are inconsistent. We are therefore prioritising this issue during 2018/19 and will audit effectiveness as part of our 2018/19 clinical audit programme.

Trust clinical audit programme

The reports of 105 local clinical audits were reviewed by the provider in 2017/18 and Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

The Trust encourages the audit of a wide variety of topics and multidisciplinary involvement. All local clinical audits are overseen by the service area in which they are conducted. Here are descriptions of 4 of those local audits and the learning we have achieved.

How BSMHFT learnt from Local Clinical Audit

Learning from local clinical audit

Searching	This re-audit looked at all new inpatient admissions to Trust in the first two weeks of January 2017, of which there were 119. The RiO records were checked for all 119 admissions for evidence of whether a search was conducted on admission to the ward as per Trust Policy. Where we found evidence that a search had happened, we also looked at whether specific details relating to the search had been documented. Ultimately, the results of the audit showed that the Trust still needed to improve its recording of searches – not only in terms of it having taken place in the first instance, but also in terms of capturing the key details about it. In addition to this, the audit process itself revealed that there is some confusion amongst clinicians about where searches need to be recorded. The results of this audit were seen as a priority across the Trust. Following on from the audit, the Trust re-wrote the Searching Policy and the Trust Security Policy (the latter of which gives further information on security measures taken to protect patients, staff and visitors). The new 'Clinical Search Policy for Service Users in Inpatient Settings' which was approved on 6 February 2018, clearly outlines who needs to be searched and when, the process to follow when conducting a search, and where these searches need to be recorded.
CQUIN 9: Alcohol and Tobacco.	As required by the Commissioning for Quality and Innovation (CQUIN) national goals, the Trust is required to demonstrate how well we try to improve the quality of the care we provide to our service users who drink alcohol and smoke tobacco. The Trust is measured on a number of areas in relation to this. Firstly, how well we screen for alcohol and tobacco usage. Then, how well we offer advice and support to those patients where we have identified excessive usage or harmful behaviour. Finally, how well we record all of this information. In relation to smoking specifically, support can be in the form of interventions such as advice on smoking cessation or offering nicotine replacement therapy. The Trust is required to submit information in relation to this on a quarterly basis. From when we began submitting this data to date, the Trust has seen a steady improvement in the number of patients we are screening and offering interventions to. Aiding this success has been the changes we made to our electronic patient information system. Initially, these changes focused on centralising where this information was recorded so that it could be easily captured and reported on. Following on from this, further changes are being made to streamline to process of recording this information in order to aide clinician's during their assessments. Rather than having to complete two separate forms when excessive smoking or drinking is identified, all of the questions will be contained within the one form.

	In addition to these changes, training around physical health is to be rolled out. This will include the training of our physical health link workers in how to record our alcohol and smoking assessments, so that they can assist other staff members in documenting this information correctly. It will also include the development of a new e-learning package around alcohol which will be made available for all staff to complete.
Blood-borne virus screening in the medium secure psychiatric hospital setting	This audit aimed to look at how well we screen the inpatients of our secure care units for blood-borne viruses. The audit process involved reviewing the records of all of the patients on two of our secure care inpatient units, in order to find how well we screen for blood-borne viruses. As well as looking at whether screening had happened at all, the auditors also looked how long it took for the screening to occur and whether the correct testing kit for screening was used. The results of the audit showed that screening take up is not 100 per cent on two of our medium secure wards. The results also showed that: it takes a year on average to screen patients; the correct testing kit was not always being used when screening patients; and that the documentation of blood borne virus status on our electronic system needs improvement. In response to these findings, a number of actions were agreed by the staff in our medium secure hospital settings. These actions included making sure that all of the patients who had not been screened for blood-borne viruses (as identified in the audit), were screened as soon as possible with the appropriate screening kit. Consultants were also asked to remind junior doctors to document any screenings, including refusals, in one place (on the appropriate electronic form). Results of the audit also prompted discussion around including blood-borne virus screening as a topic in the Trust's Junior Doctors induction.
Seclusion	The aim of the retrospective seclusion audit was to review and benchmark current practice of seclusion within the Trust. This audit sits within a larger piece of work being undertaken by the Positive and Proactive Care Expert Panel, whose remit is to transform the culture and practice of restrictive practices within the Trust. As well as the audit, panel members independently visited all sites within the Trust with seclusion suites and completed focus groups with staff and service users who had experienced seclusion. The audit looked at every episode of seclusion over a six month period, of which there were 205 episodes in our secure services and 62 in our Trust adult population. The audit found that there were discrepancies in how seclusion is used, managed and documented across the Trust. There was also evidence that post incident reviews are not widely being used.

	Results from this audit have informed improvement changes to the Seclusion and Long Term Segregation forms on our electronic records. The hope is that these changes will facilitate better documentation and increased use of post incident reviews.

Research

The number of patients receiving relevant health services provided or sub-contracted by Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 713.

Participation in clinical research demonstrates BSMHFT's commitment to improving the quality of care we offer and to making contribution to wider health improvement. In the 2017/18 financial year there were nine clinical staff participating (leading) in research approved by a research ethics committee at BSMHFT. The studies are wide ranging and covered diverse topics (including but not restricted to) Addiction, Dementia and Neurodegenerative Diseases, Neuropsychiatry, Early Intervention, Psychosis, Schizophrenia and Bi-Polar Disorder. These studies contribute to new knowledge, can involve new treatments and/or therapies that would otherwise be unavailable, can influence national policy and lead to successful patient outcomes. Our engagement with clinical research also demonstrates our commitment to testing and offering the latest treatments and techniques.

In addition, BSMHFT hosts the Clinical Research Network West Midlands (CRN:WM) Division for Dementias and Neurodegeneration, Mental Health and Neurological Disorders Management Team. The CRN team provides infrastructure and support to mental health trusts across the West Midlands to deliver research, and BSMHFT benefits by being co-located with expert staff.

Our portfolio of research is expanding and we aim to continue to support this by covering more clinical themes and training our staff (and service users) to ensure there is wide access to research. In addition, we want to support our service users, staff and carers in the development of new research and to encourage people to be 'curious' and to look for continual improvement in the quality of the service and care we provide.

Commissioning for Quality and Innovation (CQUIN) 2017/18

Use of CQUIN payment framework

A proportion of BSMHFT's income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between BSMHFT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

In 2016/17, £3,098,478 of income was conditional upon achieving quality improvement and innovation goals, of this, £2,709,591 was received and for NHS England £1,436,764 (100%) was achieved and received.

Further details of the agreed goals for 2017/18 and for the following 12-month period are available electronically at http://www.bsmhft.nhs.uk/about-us/trust-documents/statutory-statements-and-declarations/cquins-2017-18/

CCG's Contract CQUINs

No.	CQUIN Scheme	Weighing	Value
1a	Introduction of health and wellbeing initiatives	4%	£124,810
1b	Healthy food for NHS staff, visitors and patients	4%	£124,810
1c	Improving the uptake of flu vaccinations for frontline clinical staff	4%	£124,810
3a	Improving physical healthcare to reduce premature mortality in people with SMI:Cardio metabolic assessment and treatment for patients with psychoses	6%	£187,215
3b	Improving physical healthcare to reduce premature mortality in people with SMI: Collaboration with primary care clinicians	6%	£187,215
4	Improving services for people with mental health needs who present to A&E	12%	£374,430
5	Transition out of Children and young people's mental health services	12%	£374,430
9a	Preventing ill health - alcohol and tobacco - screening	0.8%	£23,402
9b	Preventing ill health - alcohol and tobacco - tobacco advice	2.3%	£70,206
9c	Preventing ill health - tobacco referral and medication	3%	£93,608
9d	Preventing ill health - alcohol screening	3%	£93,608
9e	Preventing ill health - alcohol brief advice or referral	3%	£93,608
L1a	Scheme to support engagement with STPs	20%	£624,049
L1b	Linked to the risk reserve	20%	£624,049
		100.00%	**£3,120,249**

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

Our predicted end of year CQUIN position is 86.9 per cent completion, paying £2,711,496 subject to achievement of our quarter 4 submission.

The 13.1 per cent loss is due to:

- non-achievement of 'Introduction of health and wellbeing initiatives' and 'Improving the uptake of flu vaccinations for frontline clinical staff' – 8 per cent loss
- partial achievement of 'Improving physical healthcare to reduce premature mortality in people with SMI: Cardio metabolic assessment and treatment for patients with psychoses', 'Improving physical healthcare to reduce premature mortality in people with SMI: Collaboration with primary care clinicians', 'Preventing ill health - alcohol and tobacco – screening' and 'Preventing ill health - alcohol and tobacco - tobacco advice' – 5.1 per cent loss.

NHS England CQUINs (Secure and Specialties contracts)

No.	CQUIN Scheme	Weighing	Value
Secure	Reducing Restrictive Practices within Adult Low and Medium Secure Services	14%	£431,029.20
MH3 Secure	REACHOUT	62%	£201,146.96
Secure	FCAMHS Inpatient Transitions to Adult Care	24%	£201,146.96
		100%	**£833,323.12**

MH5 - Sp	**Discharge and Resettlement - Reduction of Length of Stay in Specialised MH Inpatient Services**	**76%**	**£172,411.68**
MH2	Recovery Colleges for Medium and Low Secure Patients	24%	£431,029.20
		100.00%	**£603,440.88**

Above tables contain CQUIN goals and the financial values as agreed beginning of the financial year.

Our predicted end of year CQUIN position is 100 per cent completion subject to confirmation of achievement for our quarter 4 submission for both Secure and Specialties contracts.

Registration with the Care Quality Commission (CQC)

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

Birmingham and Solihull Mental Health NHS Foundation Trust has registration for the following activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Diagnostic and screening procedures and treatment of disease, disorder or injury.

The Care Quality Commission has not taken enforcement action against Birmingham and Solihull Mental Health NHS Foundation Trust during the reporting period.

Birmingham and Solihull Mental Health NHS Foundation Trust has participated in special reviews and investigations by the Care Quality Commission relating to the following areas during 2017/18:

- Children's Community Mental Health Care Service in Solihull.

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

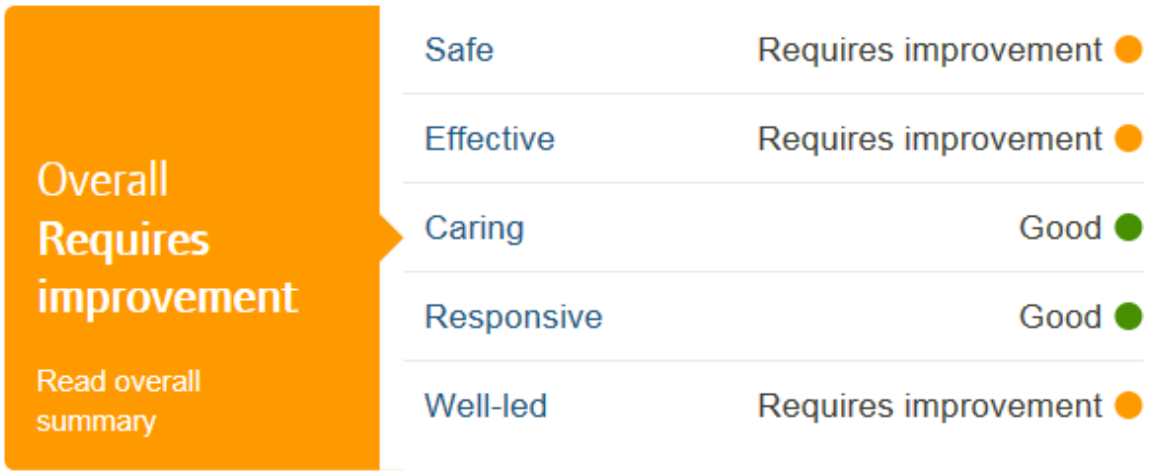
- Review the lone worker policy and its application within the service.
- Ensure care plans are detailed, personalised and holistic and that it audits the quality of these regularly.
- Increase incident awareness within the service.

Birmingham and Solihull Mental Health NHS Foundation Trust has made the following progress by 31 March 2018 in taking such action:

- The mobile phone staff safety application was not fully working or accessible on 50 per cent of staff mobile phones tested. The IT team has rectified these glitches and provided Guardian 24 training to the relevant team members.
- A quality improvement group has been established to review lone worker practices across the Trust. The first task was to create an online survey for lone workers about lone working practices. This is now live.
- Staff have been reminded during MDT and Governance meetings that all incidents are to be reported on the electronic incident reporting system. Incident analysis is scrutinised during Clinical Governance meetings and contracts review. In addition, Trustwide, we are developing practice guidance as part of an updated 'Reporting, Management and Learning from Incidents' policy and we have developed an e-learning package for incident reporting.
- Solar is now part of the Integrated Care Record audit, which looks at the presence of essential documents electronically, in addition the CPA lead has been requested to complete quality audits of Solar records at regular intervals. The first quality audit has been undertaken.

During March 2017, Birmingham and Solihull Mental Health NHS Foundation Trust received a full hospital inspection by the Care Quality Commission. This was referred to in the 2016/17 Quality Account however at this stage the rating associated with the inspection was unknown.

During the reporting period, an overall rating of Requires Improvement was awarded to Birmingham and Solihull Mental Health NHS Foundation Trust. The ratings matrix is detailed below:



We received our report in the summer of 2017 and following a range of factual accuracy checks and the conclusion of some concerns that we raised about the way in which some judgements were made, seven of our nine core services achieved a rating of good overall for the services they deliver. Our Trust overall rating has however moved to Requires Improvement with concerns cited in the safety domain in relation to our former approach to searching patients and also in relation to the storage of medications.

As a result of these concerns, we have consulted widely on a new approach to the clinical searching of patients and our new policy which came into force on 14 May 2018 is now based on individualised risk assessments. We have invested in new innovative technology to provide automated reporting on the temperatures of our medication fridges. This technology has an in built alarm system which will alert staff if the temperature of the fridge goes outside the recommended range. When temperatures move outside the recommended range this can impact on the clinical effectiveness of medication for our patients – so this is a very important development for us.

Other notable actions that we have implemented include:

- Privacy films added to consulting doors.
- Convex mirrors in place to mitigate blind spots.
- Medicines Safety Officer in post.
- New secure medication bags have been purchased for our community teams to use.
- Rapid Tranquilisation Policy reviewed, approved and implemented.
- Blanket restrictions on takeaway food have been removed.
- Cleaning schedules are in place in all areas overseen by local ward managers.

- Posters are in place in our inpatient and community buildings in the top five languages used by our population, advising patients how they can access patient information and support services.
- The Equality Delivery System 2 is now in place across the Trust.
- The Board Assurance Framework has been redeveloped and we have sought external assurance on its efficacy.

We continue to work hard to implement our action plan arising from the inspection and hope that we will move to a rating of 'Good' for the Trust when our next inspection takes place.

Improving data quality – Data sets: NHS number and general medical practice code validity

Birmingham and Solihull Mental Health NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

- 99.5 per cent for admitted patient care
- 99.9 per cent for outpatient care.

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

- 98.9% per cent for admitted patient care
- 99.0% per cent for outpatient care.

Information governance toolkit attainment levels

Birmingham and Solihull Mental Health NHS Foundation Trust's Information Governance Assessment Report overall score for 2017/18 was 75 per cent and was graded green.

Payment by results clinical coding

Birmingham and Solihull Mental Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Data quality actions

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

- Maintaining regular assessment of the quality of data underlying all key performance measures so that any issues can be addressed.
- Continuing detailed audit and review of the accuracy of clinical case classification, activity monitoring and clinical outcome measurement information.

- On-going comparison of service user contact and GP registration details with the national NHS Summary Care Record database to ensure information in our clinical systems stays up-to-date.
- Close monitoring and continuous quality improvement work on a range of data quality performance indicators, with clinical and administrative staff using monitoring reports to identify and correct data errors.
- A range of data quality audits covering all key reporting data sets, with special in-depth audits and corrective work if significant data quality problems are identified.

National quality indicators

The NHS Outcomes Framework sets out a series of care outcomes services should strive for in relation to clinical quality, patient safety and patient experience. It defines measures related to those outcomes and we report regularly to the Department of Health on our performance against those measures. The Department of Health identified 15 of those measures that should be included in Trust Quality Accounts where relevant. Six are relevant to Birmingham and Solihull Mental Health NHS Foundation Trust services:

1. Follow-up within 7 days of discharge from inpatient care.
2. Home treatment team gatekeeping of admissions to acute wards.
3. Readmission to hospital within 28 days of discharge.
4. Patient experience of community mental health services.
5. Patient safety incidents.
6. The Staff Friends and Family Test.

1) Follow-up within 7 days of discharge from inpatient care

The percentage of service users being treated under the Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care:

This indicator identifies whether people with a mental illness discharged from our inpatient wards have a direct face-to-face or telephone follow-up contact with a member of clinical staff on at least one of the seven days following discharge. The measure aims to ensure that service users are protected at a time of significant vulnerability and appropriately supported through their transition back into day-to-day life outside hospital. The quoted national figures are for all mental health trusts.

	Birmingham and Solihull Mental Health NHS Foundation Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2017-18	96.1%	96.1%	99.4%	79.9%
2016-17	97.0%	96.6%	99.4%	59.5%
2015-16	96.9%	97.0%	99.8%	82.8%
2014-15	95.7%	97.2%	100.0%	95.0%

Data Source: RiO - our internal clinical information system

Our local methodology excludes three groups of service users where the exclusion is not explicitly defined in national guidance, as follows:

- People discharged to non-NHS psychiatric hospitals, because they continue to be under the direct 24-hour care of qualified mental healthcare staff.
- People discharged to an overseas address are excluded from the indicator due to the challenge of contacting people outside the United Kingdom.
- People discharged from our neurological investigations unit because their admissions do not relate to acute psychiatric illness.

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

- A process audit of the Trust's methodology has confirmed that our processes and calculations adhere to national reporting definitions.
- Regular samples of records are compared with clinical progress notes to ensure that they are being correctly included or excluded from indicator calculations.

Birmingham and Solihull Mental Health NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, by monitoring adherence to our Trust's policy on community follow-up of inpatient discharge, undertaking regular sample audits and feeding back results to clinical teams, and by ensuring oversight of this process is maintained through circulation of weekly reports to senior managers and review at regular divisional performance meetings.

2) Home treatment team gatekeeping of admissions to acute wards

The percentage of admissions to acute wards for which a crisis resolution / home treatment team acted as a gatekeeper.

This indicator identifies whether crisis resolution or home treatment teams had assessed people admitted to hospital and been involved in the decision to admit and, therefore, measures our success in ensuring that people are not admitted to hospital where they could be more appropriately cared for in their own home or another community location. As such, it is a measure of both quality of care and efficiency of resource use. National definitions exclude transfers from other hospitals, including A&E Departments, so the measure is looking at people admitted from their own homes or other community locations. Our local definitions would also consider admissions as having been 'gate-kept' where there was involvement from an assertive outreach or RAID team, as these teams also provide a crisis resolution service and consider alternatives to admission as part of their assessments. The quoted national figures are for all mental health trusts.

	Birmingham and Solihull Mental Health Foundation Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2017-18	96.2%	98.6%	100%	93.8%
2016-17	97.3%	98.5%	100%	89.8%
2015-16	97.4%	97.3%	100%	64.7%
2014-15	97.2%	98.1%	100%	82.7%

Data Source: RiO - our internal clinical information system

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

- A process audit of the Trust's methodology has confirmed that our processes and calculations adhere to national reporting definitions.
- Regular samples of records are compared with clinical progress notes to ensure that they are being counted correctly in indicator calculations.

Birmingham and Solihull Mental Health NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, by ensuring oversight of this process is maintained through monthly review and targeted reports to senior managers.

3) Readmissions to hospital within 28 days of discharge

The percentage of admissions to Trust hospitals of patients aged:

(i) 0 to 15 and
(ii) 16 or over

which were readmissions within 28 days of discharge from a hospital which forms part of the Trust. There is no national indicator meeting exactly this definition. Trust data is based on all readmissions happening on the same day as a discharge from Trust inpatient services or any of the following 27 days.

This indicator measures quality of inpatient care, discharge arrangements and ongoing community support by identifying the extent to which service users discharged from hospital need to be readmitted within 4 weeks, our Trust's aim being to keep early readmissions to a minimum. National comparison figures are not available.

There is no national data available for comparison for this indicator.

	Age 0-15	Age 16+
2017-18	0.0%	5.6%
2016-17	0.0%	5.0%
2015-16	0.0%	6.5%
2014-15	0.0%	6.3%

Data source: RiO – our internal clinical information system

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

- Admission and discharge dates, and service user dates of birth, are audited regularly as part of the Trust's routine data quality audit programme.
- Service user dates of birth are also subject to regular validation against information held on the NHS national Summary Care Record.

Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following action to improve these percentages and so the quality of its services, by ensuring oversight of this process is maintained by monthly reporting and review at regular divisional performance meetings.

4) Patient experience of community mental health services

The Trust's mean 'Patient experience of community mental health services' indicator score (out of 10) with regard to a patient's experience of contact with a health or social care worker as reported through the 2017 National Community Mental Health Service User Survey.

The quoted national figures are for all mental health trusts.

This is a composite score derived from questions in the national community mental health survey 2017 relating to satisfaction with health and social care workers. The 2017 score cannot directly compare with previous years' due to changes in the question and in time period of survey collection and results publication, however the score can be compared across trusts.

	Birmingham and Solihull Mental Health Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2017-18	7.4	7.3	8.1	6.4
2016-17	7.5	7.5	8.1	6.9
2015-16	7.3	7.5	8.2	6.8

Data source: National Community Mental Health Service User Survey

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

The survey is undertaken independently to the Trust by an external company in accordance with national survey requirements and the results are in line with our expectations.

Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve this percentage:

- Create an overarching Trustwide Recovery Strategy - the draft strategy is out for consultation.
- 111 poster, before you go to A&E.
- Design and roll out co-designed training on my care and recovery ideally through the Recovery College; what's important in my care, this would include the three areas we prioritised from the patient survey and be co-designed and delivered by Experts by Experience.
- Focus groups with service users about crisis plans, what they would like in them. CPA lead to include in the care planning redesign work.

5) Patient safety incidents

The number and rate of patient safety incidents reported within the Trust, and the number and percentage that resulted in severe harm or death.

Figures released by the National Reporting and Learning System (NRLS) are reported six – twelve months retrospectively and are only therefore a reflection of harm levels caused by incidents at during that data period. The quoted national figures are for all mental health trusts.

	Reported Patient Safety Incidents per 1000 bed days				Percentage of Patient Safety Incidents resulting in Severe Harm or Death			
	Trust	National Median	Highest National	Lowest National	Trust	National	Highest National	Lowest National
Apr 17 – Sep 17	35	51	126	16	0.5%	1%	3.7%	0.1%
Oct 16 – Mar 17	36	46	88	11	0.6%	1.1%	4.7%	0.1%
Apr 16 – Sep 16	40	42	89	10	0.5%	1.1%	6.1%	0.3%
Oct 15 – Mar 16	40	38	85	14	0.5%	1.1%	6%	0.1%
Apr 15 – Sep 15	42	39	84	6	0.6%	1%	3.7%	0
Oct 14 – Mar 15	47	31	93	5	0.5%	1.1%	5.1%	0%
Apr 14 – Sep 14	43	33	90	9	0.8%	1.0%	5.9%	0%
Oct 13 – Mar 14	47	26	59	9	0.8%	1.1%	5.4%	0.2%
Apr 13 – Sep 13	41	26	67	0	1.1%	1.3%	5.4%	0%

	Patient Safety Incidents – Total Reported	Patient Safety Incidents per 1000 Bed days	Patient Safety Incidents resulting in Severe Harm or Death	% Patient Safety Incidents resulting in Severe Harm or Death
Apr 17 – Sep 17	4013	35	24	0.5%
Oct 16 – Mar 17	4279	36	26	0.6%
Apr 16 – Sep 16	4681	40	21	0.4%
Oct 15 – Mar 16	4856	40	22	0.5%
Apr 15 – Sep 15	5040	42	29	0.6%
Oct 14 – Mar 15	5550	47	31	0.5%
Apr 14 – Sep 14	5086	43	39	0.8%
Oct 13 – Mar 14	4840	47	40	0.8%
Apr 13 – Sep 13	4106	41	44	1.1%

Data source: National Reporting and Learning System (NRLS)

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

Data is submitted regularly to the National Reporting and Learning System (NRLS) from the Trust's incident reporting system (Eclipse). Any re-classification of incidents in relation to cause or harm flags up the incident locally and it is resubmitted to the NRLS; the new record overwrites the original to avoid duplication. The coding of incidents in relation to harm and classification is subjective and there is variation between Trusts.

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

- Continuing to deliver incidents reporting training and incidents awareness sessions.
- We are developing practice guidance as part of an updated 'Reporting, Management and Learning from Incidents' policy and we are soon to launch an e-learning package for incident reporting.
- Reintroducing governance and incident reporting at Trust induction.
- We realigned our incident classifications categories in April 2017 following a national project led by BSMHFT to compare classifications categories with 17 other trusts.
- We have introduced shorter incidents forms on Eclipse.
- We will continue to develop and promote the utilisation of the Black Hole, our innovative governance intelligence analytics portal, providing in-depth automated analysis of incidents data from ward to board.
- We will realign incident management timelines in line with other trusts nationally.
- We will improve the learning lessons framework and promote adoption through new practice guidance.
- Thematic reviews of incidents and reporting trends.

6) Staff Friends and Family Test

The percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends, as reported in the NHS National Staff Survey.

The quoted national figures are for all mental health trusts.

	Birmingham and Solihull Mental Health Trust	National Average	Highest Reported Score Nationally	Lowest Reported Score Nationally
2017-18	54%	61%	84%	42%
2016-17	57%	59%	82%	45%
2015-16	62%	59%	81%	36%
2014-15	62%	59%	84%	36%
2013-14	60%	59%	85%	41%
2012-13	60%	58%	80%	44%

Data source: National NHS Staff Survey 2017

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

The survey is undertaken independently to the Trust by an external company in accordance with national survey requirements.

Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services by:

Over the last 12 months we have implemented targeted health and wellbeing initiatives. There is a need to now strengthen these initiatives further with more targeted support implemented in conjunction with service areas and to continue to focus on key areas such as stress and musculoskeletal, with service areas leading on the delivery of these plans.

Focused work around the Dignity at Work Programme combined with the policy launch and awareness sessions has had a strong impact in terms of raising awareness and encouraging staff to report bullying and harassment and violence in the workplace.

The Trust has also undertaken significant work around the review and relaunch of staff networks, and various other initiatives as part of the Equality Delivery System (EDS2) and Workforce Race Equality Standard (WRES) which have provided a strong foundation to now embed this further and facilitate culture change through training, awareness and support so as to improve staff experience, create a culture of compassionate care and reduce bullying and harassment and promote equality in the workplace.

Following the last staff survey we have also implemented an innovative and evidence based approach around team effectiveness, in conjunction with Aston OD. We have completed the recruitment and training phase of this project and are now in the process of piloting the programme prior to full roll out across the Trust. It is important this piece of work is fully embedded in order to evaluate the effectiveness of the programme and see any positive outcomes associated with the staff survey.

In addition to the above, in order to build an effective response we want to understand what staff have said in detail. We will therefore be closely analysing the data published along with the results from the spring 2018 ProActive Pulse Check and other engagement work such as Listen Up Conversations.

That work will help us to develop a renewed set of actions based on staff feedback and involvement. This will build on existing activity outlined earlier and like last year will include targeted activity developed by service areas. The focus will be on what staff have told us in the survey and what more we need to do to work toward our strategic ambition to attract, develop and support an exceptional workforce.

More detailed information relating to the staff survey and indicators mentioned above can be found in the staff survey section of the staff report earlier in this annual report.

Learning from deaths

The national guidance for LFD (National Quality Board reference) states that ‘as a minimum and from the outset, Trusts should focus reviews on inpatient deaths’ and ‘In particular contexts, and as these processes become more established, Trusts should include cases of people who had been an inpatient but had died within 30 days of leaving hospital’
Within BSMHFT, we have decided to go beyond these minimum requirements, and to not only include inpatients but also to review the care of active patients on our community caseload and those patients who have died within six months of discharge from our services. Whilst this means that potentially our figures will seem higher than those reported in other organisations, we believe that it is important to take advantage of all learning opportunities, so that we can ensure that we are working towards providing the safest services possible. As a result of this process we have clinically triaged 719 of the 774 deaths reported via our incident reporting system during the year.

The triage process identified that 62 of the deaths required a Mortality Casenote Review and 35 of the deaths required a Serious Incident Root Cause Analysis investigation. Of these, 8 of the deaths were identified as probably avoidable.

Within the 8 deaths associated with a problem with care, there are some emerging themes that we need to act upon in 2018/19 to ensure that we learn from these cases in the future. These include improved family and carer involvement and engagement; increased use of longitudinal risk assessment and increased recognition of suicidal risk factors when conducting risk assessments, care plans and crisis plans. These all feature within aspects of our Quality Goals for the Trust for 2018/19.

During 2017/18 774 of Birmingham and Solihull Mental Health NHS Foundation Trust patients died*. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 197 in the first quarter
- 201 in the second quarter
- 185 in the third quarter
- 191 in the fourth quarter.

*as per recorded on the Trust's incident reporting system Eclipse

By 10 April 2018, 62 case record reviews and 35 investigations have been carried out in relation to 97 of the deaths included above.

In 0 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 41 in the first quarter
- 39 in the second quarter
- 14 in the third quarter
- 3 in the fourth quarter.

Eight deaths, representing 1.03 per cent of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 2 inpatients representing 1.015 per cent and 2 community patients representing 1.015 per cent which is in total 4 representing 2.03 per cent for the first quarter.
- 4 community patients representing 1.99 per cent for the second quarter.
- 0 representing 0 per cent for the third quarter.
- 0 representing 0 per cent for the fourth quarter.

These numbers have been estimated using the serious incident root cause analysis approach and supplemented with a mortality scoring methodology as specified below:

1 Definitely avoidable
2 Strong evidence of avoidability
3 Probably avoidable (more than 50:50)
4 Possibly avoidable, but not very likely (less than 50:50)
5 Slight evidence of avoidability
6 Definitely not avoidable

Given the small sample size, it has been difficult to identify any material learning on a thematic basis at this stage, however individual investigations have identified some learning relevant to our approach to multi-agency care (such as drug and alcohol services), family/carer involvement and engagement and also some deficits in recognising the impact that major life events had on patient risk profile and a lack of consistent longitudinal risk assessment. A unique issue relating to the risk associated with patients with swallowing difficulties has also been identified.

In response to the issues we have found we have taken the following actions:

- We have encouraged formal clinical referral letters to be written to drug and alcohol services rather than relying upon signposting arrangements which are reliant upon the service user.
- Our suicide prevention training has been updated to reinforce the impact that significant life events can have on risk.
- An e-learning pack for dysphagia will be developed during 2018/19.
- Scope all opportunities (existing and future) for co-production and family, carer and service user involvement from ward to board.
- Roll out of the family and carer pathway pilot programme including signposting for carers and carers assessments.

Due to the small sample size and the timeliness of action deployment it would be premature to try to assess the impact of actions.

0 case record reviews and 14 investigations completed after 31 March 2017 which related to deaths which took place before the start of the reporting period.

0 representing 0 per cent of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This is because the avoidability scoring process in the Trust was adopted for deaths that occurred from 1 April 2017 onwards.

0 representing 0 per cent of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient. This is because the avoidability scoring process in the Trust was adopted for deaths that occurred from 1 April 2017 onwards.

National mental health indicators

This table shows our Trust's performance against the national mental health indicators as set out in Appendices 1 and 3 of NHS Improvement's Single Oversight Framework.

National mental health indicators

	NHS Improvement Single Oversight Framework (SOF) updated in November 2017: National Indicators – 2017/18	National Threshold	2017/18
1	Early intervention in Psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral. Ⓐ	50%	90.5%
2	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards b) early intervention in psychosis services c) community mental health services (people on care programme approach)	 90% 90% 65%	 70.87% Not available 34.5%
3	Improving access to psychological therapies (IAPT): a) proportion of people completing treatment who move to recovery (from IAPT dataset) b) waiting time to begin treatment (from IAPT minimum dataset): i. within 6 weeks of referral ii. within 18 weeks of referral	 50% 75% 95%	 51.2% 95.9% 100%
4	Admissions to adult facilities of patients under 16 years old	n/a	0
5	Inappropriate out-of-area placements for adult mental health services (average bed days per month) ** Ⓐ	n/a	138

** Out-of-area placement figures cover January to March 2018 only as this measure was added to national performance reporting frameworks from January 2018

Section three

Review of quality performance

Safety

- Risk assessment and policy training
- Searching and security
- Safeguarding

Effectiveness

- Care Programme Approach
- Accreditations
- Comparing practice against evidence based guidance: Eating Disorders
- Solihull community services for children and young people - Solar
- Effective information in Accident and Emergency departments
- Complementary therapies on Caffra Psychiatric Intensive Care Unit (PICU)
- PLACE results 2017 (Patient Led Assessments of the Care Environment)

Experience

- NHS Friends and Family Test
- Families, friends and carers engagement
- SeeMe service user engagement
- Complaints investigations – highlights and challenges
- Secure Care – improving patient experience
- HMP Birmingham – better prisoner engagement

Safety

Our Trust identified the following key indicators for monitoring the quality of safety in addition to the indications in chapter 2 of this report. These indicators all complied into one integrated quality report which is presented quarterly to the Trust Clinical Governance Committee and then the Integrated Quality Committee.

Safety indicators

	2015/16	2016/17	2017/18
Numbers of Incidents reported	20,156	17,588	16,291
Riddor reportable incidents	100	33	85
Serious incident reports (by date of incident)	142	123	100
Serious incident reports (by reported date)	144	121	105
Clostridium Difficile Infections	**0**	**0**	**0**
Never Events #	**0**	**0**	**0**
MRSA infections	**0**	**0**	**0**
Level 1 Suicide Prevention Training	na	84%	96.8%
Health and safety training	98.7%	97.1%	95%
The management of violence and aggression training – AVERTS 5 day training	95.7%	98.4%	97.4%

There have been no changes in the way the data has been calculated.
There is no national data to benchmark this data with.
The above data was taken from our Trust's incident reporting system - Eclipse. The last 2 figures regarding training were taken from the Trust's training system – Oracle. Both are internal systems and internal measures.
 # - as defined by national standard definitions

The data demonstrates continued excellence in the field of infection control, a reduction of serious incidents in the Trust and continued high performance levels of our training associated with risk.

Risk assessment policy and training

At the beginning of the year the Clinical Risk Assessment and Management Policy underwent a fundamental review by our Clinical Risk Lead. The purpose of this policy is to promote service user, staff and public safety by ensure a systematic approach to risk assessment and management at an individual practitioner, team and organisational level in order that the range of relevant clinical risks can be identified and then managed effectively and safely. The policy outlines the responsibilities of the Trust, teams and individuals in assessing and managing risk and recording risk information. Within this document 'clinical practitioners' are those staff where competency in clinical risk assessment, formulation and management is required to fit their role.

The policy describes the following:

- The principles underlying clinical risk assessment in BSMHFT.
- The system for managing clinical risk assessment documentation within BSMHFT; and
- The training and post-training support that is provided to staff to support the practice of clinical risk assessment across all directorates.

In 2018/19 we will be revitalising the training and reviewing the documentation process on RiO to ensure that it meets the needs of clinical practice.

Searching and security

One of the larger and more complicated pieces of work this year has been to our searching process on inpatient units. Issues had been raised from clinical audits, serious incidents, external visits and inpatient staff. A review found that searches had become the sole responsibility of nursing staff, searching had taken on a blanket approach to all patients and security issues were ingrained within clinical practice. We held a Listen Up event in August 2017 to consult on current practice and the best way forward. It was agreed that what we actually needed was to separate out searching and security of buildings. In February 2018 we approved both the 'clinical search policy for service users in inpatient settings' and the security policy. In addition we are about to launch online searching training. The security policy introduces the requirement for metal detectors, property lockers, and security officers. The policies are designed to work in tandem and ease some of the pressure on clinical staff.

Safeguarding

Quality improvement measures

In 2017/18 The Safeguarding Team started a three year project to develop a new clinical quality assurance framework with associated performance measures (KPIs), baseline operating standards and audit programme. The first tranche of safeguarding practice guidance was finalised in January 2018 and is due to be introduced, alongside the new guidance for Right Help Right Time, in a series of workshops commencing in April 2018.

The Dementia and Frailty Senior Management Team, in conjunction with Safeguarding staff, have strived to drive improved quality of care by providing a more visible presence within inpatient facilities in order to promote good safeguarding practice. To support this, the service manager and matrons initiated a safeguarding event for all staff which was very well attended and there are plans to repeat this event in the future.

Learning into Practice

The Safeguarding Team continues to promote a learning culture. During 2017/18, the Named Nurse for Domestic Abuse has delivered a series of sessions across the Trust to discuss and distribute learning from our thematic review of the recommendations from domestic homicides.

The Safeguarding Team has delivered training on modern slavery, forced marriage and also quarterly full-day sessions on child sexual exploitation which are facilitated in partnership with Solar/Barnardo's.

With the support of partners and colleagues, the Safeguarding Team hosted its annual conference 'Simplifying Adult Safeguarding' on 20 March 2017.

This conference was delivered in response to the team's analysis of advice calls which suggested that staff had some gaps in their understanding about early intervention when adult safeguarding risks and vulnerabilities were identified. The conference, which was co-produced with partner agencies and carer groups, featured a theatre production which was funded by the Trust's Caring Minds charity. The production was developed by LoudeemY Productions and used actual service user experience within its content. The Safeguarding team has focused on local learning by introducing the use of reflective practice sessions in the form of table top reviews of specific cases. These sessions have been very well received and have improved practice in a number of teams, some of whom have gone on to be awarded Safeguarding Best Practice Awards.

Working in Partnership

The Safeguarding Team has participated in numerous partnership forums during 2017/18. The Head of Safeguarding has taken up the role of Chair of the Safeguarding Adult Review Sub Group of Birmingham Safeguarding Board and is working with the Birmingham Early Help Partnership Board to improve the interface with other agencies regarding 'Early Help' provision for children and young people. She has also participated in a working group which initiated a review of the Birmingham response to neglect. This review continues in conjunction with Leeds Safeguarding Children Board.

Effectiveness

The Trust identified the following key indicators for monitoring the quality of safety. These were identified in the previous report and following review, they were still deemed to be a priority.

For people on CPA	**2015/16**	**2016/17**	**2017/18**
Completion of CPA care plan	84.3%	88.3%	82.4%
Completion of risk assessment	84.4%	86.3%	81.9%
Completion of Summary Assessment (previously known as the Health and social care assessment)	84.8%	86.9%	81.5%
CPA review in the previous 12 months	96.4%*	92%	97%
For people on Care Support	**2015/16**	**2016/17**	**2017/18**
Care Support Care plan	Data unavailable	61.3%	63.5%
Risk Assessment	Data unavailable	50.5%	52.3%
Assessment Summary	Data unavailable	67.3%	69.9%

There is no national data that we have benchmarked this data with.
There have been no changes in the way the data has been calculated.
Data source is the ICR report on INSIGHT, our internal reporting system, there are no national standard definitions for this data.

Care Programme Approach

Our Care Management and CPA/Care Support Policy requires all service users receiving treatment and care from Birmingham and Solihull Mental Health NHS Foundation Trust to be provided with a care plan, developed in partnership with them, which is clear and accessible. The care plan should include an agreed plan of the steps to take in a crisis. In order to achieve compliance with policy standards the CPA team have undertaken the following actions:

Monitoring compliance with Key CPA Standards

In conjunction with the Clinical Governance Team and Information Team electronic reporting mechanisms have been developed and have been in place for a number of years; these reports measure compliance for all CPA core documentation including CPA, inpatient and care support plans.

Following the Healthwatch Birmingham investigation into the number of service users in Birmingham who have a care plan, a single care plan reporting methodology was established. The Trust provided Healthwatch Birmingham with regular updates on progress. The Healthwatch Birmingham Annual Report 2016/2017 published the following:

- The number of service users with a current care plan had risen from 74.4 per cent at the beginning of January 2017 to 84.9 per cent at the end of March 2017.
- The number of inpatients with a care plan had risen from 54.3 per cent at the beginning of January 2017 to 89.9 per cent at the end of March 2017.
- The number of service users with a current care support plan had risen from 54.3 per cent at the beginning of January 2017 to 70.4 per cent at the end of March 2017.

The percentages above are distinct from the ones on the table on the previous page, as they relate to the presence of a care plan, rather than its completeness. The CPA team provides commissioners with quarterly reports which detail the numbers of service users with a current risk assessment and the number of service users with a current care plan.

Monitoring quality of risk assessments and care plans

A rolling programme of audits monitoring the quality risk assessment and care plans has been established and are applicable to all clinical services. The tool includes a number of national and local quality standards and includes Care Quality Commission recommendations and the Mental Health Act Code of Practice. Audits are carried out by team managers and validated, analysed and reported by the CPA team. The results of these audits are reported and monitored by the Clinical Effectiveness Group, and Clinical Governance. Quality reports are also submitted to the Commissioners on a quarterly basis.

Crisis planning

An assurance review audit of crisis planning was undertaken in September 2017 by the CPA Team and internal auditors TIAA. A number of recommendations were made and an action plan was developed to ensure that services users who are at risk of a crisis will have a personal risk and safety plan that meets NICE Quality Standards, which includes early warning signs of a crisis and coping strategies, details of advanced statements and decisions, the practical needs of the service user if they are admitted to hospital, involvement of family and carers and information about 24 hour access to services and named contacts

Care planning training programme
The CPA team have delivered care planning training for all qualified clinical staff for a number of years. Training has recently been extended to include Associate Nurse staff. Training is delivered via a number of formats; formal half day training sessions, on-site team training sessions or individual mentoring and support.

The CPA team will now extend training to student nurses who will be working within this Trust as part of the Student Experiential Learning Framework (SELP).

Care Quality Commission (CQC) inspection
The CQC inspection found that some care plans provided clear evidence of service user involvement in the process but stated that there needs to be a 'consistent approach to the recording of care planning documentation'.

A listening and engagement event took place following the report and the CPA team commenced a programme of improvement in April 2018, which is still ongoing, to ensure that:

- there is a uniform and consistent format for care planning for all service users

- care planning documentation is streamlined to improve functionality and to enable clearer identification and recording of service user involvement, views, preferences and decisions about care.

Accreditation achievements
Accreditation works to assure our service users, staff, carers, commissioners and regulators that the quality of the services we as a Trust provide, are as they should be.

Accreditation for Inpatient Mental Health Service (AIMS)
AIMS works with services to improve the quality of inpatient mental health services. Through a comprehensive review process involving staff and service users, it recognises high standards of patient care and highlights any areas for improvement. The following wards within our Trust have received AIMS accreditation:

- Bergamot ward ***Older Adults***
- Sage ward ***Older Adults***
- Ashcroft Inpatients ***Older Adults***
- Rosemary ward ***Older Adults***
- Reservoir Court Inpatients ***Older Adults***
- Dan Mooney House ***Solihull***
- David Bromley House ***Solihull***
- Grove Avenue ***South***
- Forward House ***North and West***
- Endeavour Court ***North and West***

Hertford House had previously been accredited as 'excellent' and has completed the process for re-accreditation. There is one outstanding action relating to Occupational Therapy support. Once addressed, the process can be completed.

Psychiatric Liaison Accreditation Network (PLAN)
PLAN works with services to improve the quality of psychiatric liaison hospital settings. PLAN involves staff and patients in a review process where good practice is acknowledged and support is given to services to address any areas for improvement.

The following teams have received PLAN accreditation:

- Heartlands RAID
- City RAID
- Good Hope RAID

Quality Network for Inpatient CAMHS (QNIC)
Within our Secure Care areas, Forensic CAMHS have received the QNIC accreditation. Through a process of peer review using QNIC service standards, this network works to improve the quality of child and adolescent psychiatric inpatient care.

Memory Services National Accreditation Programme (MSNAP)
In May 2015, our Memory Assessment Service (MAS) received national accreditation. The principles that have guided the development of the MSNAP standards state:

- People with memory problems/dementia should have fair access to assessment, care and treatment on the basis of need, irrespective of age, gender, social or cultural background, and are not excluded from services because of their diagnosis, age or co-existing disabilities/medial problems.
- People with memory problems/dementia and their carers should receive a service that is person-centred and takes into account their unique and changing personal, psychosocial and physical needs.

Electroconvulsive Therapy Accreditation Service (ECTAS)
ECTAS assists ECT services to improve the quality of the administration of electroconvulsive therapy. Our ECT clinic based at The Oleaster accredited with ECTAS.

National Autistic Society Accreditation
The Forensic CAMHS service was awarded the National Autistic Society Accreditation. This aims to improve the quality of the service delivered to individuals with Autism and Asperger syndrome.

National Association of PICU (NAPICU)
The aim of the National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) is to advance the care and treatment of those people who require psychiatric intensive care and low secure units in acute services.

- Eden PICU - Accredited.

Quality Network Accreditation

Our Specialities services have received the following Quality Network Accreditations:

- Eating Disorders (Cilantro Suite) – Accredited by the Quality Network for Eating Disorders in July 2016
- Deaf Service (Jasmine Suite) – Accredited by the Quality Network for Inpatient Mental Health Services for Deaf People.
- Mother and Baby Unit (Chamomile Suite) – Accredited by the Quality Network for Perinatal Mental Health in May 2016*

**To note - there is an accreditation process for perinatal community teams. They are part of the network and are participating in the cycle of peer reviews as part of the initial accreditation process. They plan to complete the application process in 2019.*

Quality Network for Forensic Mental Health Services

The Quality Network for Forensic Mental Health Services adopts a multidisciplinary approach to quality improvement in medium and low secure mental health services. All our forensic units have achieved this accreditation.

Comparing practice against evidence based guidance: Eating Disorders

As a Trust it is crucial that we offer the best, most up-to date, evidence-based care to the patients we look after. One way in which we can check if we are doing this, is by comparing our practice to the standards set out by the National Institute for Health and Excellence (NICE).

The process for doing this comparison involves looking at all of the recommendations connected to a NICE guideline and assessing whether we are meeting each recommendation. Where we are not meeting all of the recommendations, we try to identify ways of rectifying this.

One such assessment was recently undertaken by our Eating Disorder services. The teams that make up these services looked at all of the recommendations detailed in the current NICE *Eating Disorders: Recognition and Treatment* Guidance, and then judged whether they felt they were meeting them. The results of this process were reassuring. They revealed that our Eating Disorder services are compliant with 95 per cent of the recommendations set out by NICE. One area where they did particularly well and met 100 per cent of the recommendations was in working collaboratively with other healthcare teams to support effective treatment of physical or mental health co-morbidities in people with an eating disorder. Another area where the teams achieved 100 per cent compliance was in appropriately admitting people with an eating disorder to a medical inpatient or day patient service for medical stabilisation and to initiate re-feeding if their health is severely compromised.

There were a small number of recommendations that the Eating Disorder services were not meeting at the time of the assessment. One of these included providing written information for family and carers who do not attend assessment or treatment with the person who has the eating disorder. Although written information was being provided for carers involved with our inpatient service, this was not happening in our outpatient service. Since the assessment identified this deficit, work has begun to rectify this.

The outpatient service is liaising with the inpatient service to build on the existing information pack they already provide for carers. In addition, the service is considering restarting the 'caring for carers' group, which will be open to all carers regardless of which eating disorder service the person they are caring for is accessing.

Solihull community services for children and young people - Solar

Following the Trustwide CQC inspection in March 2017, the Solar service was rated to be an 'inadequate' service by the CQC. Solar provides emotional wellbeing and mental health services for children and young people in Solihull, in partnership with Barnardo's and Autism West Midlands.

Once the report had been received, which outlined the reasons for this rating, an action plan was developed to address each point raised. This included concerns that the ability to consent to treatment (known as Gillick competence in young people) was not assessed, nor was their consent to treatment recorded. The parent responsible for the child or young person was not clearly identified in the records, and their consent was not documented for those children who were not Gillick competent. To address this, an information sheet was developed which outlined important aspects of treatment, such as the right to confidentiality. Every person who enters the service (or their parent) is given this information and this is discussed with them to ensure they have understood it and any questions can be answered. The assessment of Gillick competence and consent to treatment are then recorded in clinical records as a permanent record that this discussion has taken place.

The report also highlighted some shortcomings in the buildings. The clinic didn't have a lockable cupboard for the safe storing of prescription pads, and this has since been ordered, installed and is in use. The shared waiting rooms didn't have a clear mechanism for monitoring who was entering or leaving a building, so a video entry system was installed. Alarms are also now in place to allow staff to summon help quickly should it be needed. The report identified some shortcomings in the training records for staff, and the uptake of supervision and appraisal rates. The numbers of staff who are now up to date with training, supervision and appraisal is now above the Trust targets.

All of this work is underpinned by policy and procedures, which have either been written or updated since the inspection to strengthen the implementation of these actions.

The CQC undertook a further inspection in January 2018, and this time rated the service as 'good'. They acknowledged the hard work that the core leadership team had put into developing the action plan and addressing the concerns raised in 2017. They also acknowledged all the hard work of all the staff within the service to carry out the action plan, input and feedback about changes in service practice and in continuing to provide clinical care.

Complementary therapies on Caffra (PICU)

The idea to introduce complementary therapies on the Caffra unit came about when the Trust introduced the no smoking policy in 2016. The team realised this would be a challenge for a lot of their service users and so began thinking of ways to support them.

The team employed a therapist for one day a week initially to provide complementary therapies, the sessions offered include; relaxation techniques, hand, head and shoulder massage, acupuncture and aromatherapy. The sessions were so popular they increased this to offer sessions two days a week, and following further patient feedback they have requested to increase this to three days. To allow flexibility, service users are able to directly refer into sessions themselves or may be signposted by staff. The sessions are facilitated in the new designated relaxation room on the ward, which includes relaxing music, lighting, soft furnishings such a massage couch. The room is continually being developed following feedback from the service users on the ward. Staff report really positive feedback from service users, one reporting it to be 'better than any medication' another that it 'helps with abstinence from smoking'.

The team on Caffra has received recognition from the National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) for its complementary therapy room. It is leading the way and is actually the only PICU nationally with a complementary therapist and a dedicated space for the therapy to take place. The model on Caffra was deemed to be such a success that this led to other acute wards bidding for funding for relaxation rooms.

PLACE results 2017 (Patient Led Assessments of the Care Environment)

The aim of PLACE assessments is to provide a snapshot (on the day) of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care (cleanliness; the condition, appearance and maintenance of healthcare premises; the extent to which the environment supports the delivery of care with privacy and dignity; and the quality and availability of food and drink).

In 2015 the assessments were extended to include criteria on how well healthcare providers' premises are equipped to meet the needs of caring for patients with dementia. It should be noted that this does not represent a comprehensive assessment relating to dementia; rather it focuses on a limited range of aspects with strong environmental or building associated components.

In 2016 the assessments highlighted for the first time how well healthcare providers' premises are equipped to meet the needs of people with disabilities. It should be noted that this does not represent a comprehensive assessment relating to disability but rather it focuses on a limited range of aspects with strong environmental or building associated components.

As with the previous PLACE programmes, service user representatives must make up at least 50 per cent of each assessment team and where possible one should be appointed as the PLACE Assessment Team Lead. BSMHFT's PLACE programme again had excellent support from a highly motivated team of service user representatives and from the patient and public involvement team.

The latest results available are for the 22 assessments that were completed during March to June 2017. For each assessment service user representatives made up at least 50 per cent of the team which comprised:

• Service User Representatives 2/3	• Facilities Representative (stood down if less than three Service Users)
• Matron	• PLACE Administration Manager (from Estates and Facilities)

How did we do?
BSMHFT's overall organisational scores exceeded the national average scores in all six categories.

For cleanliness, BSMHFT is one of 12 NHS trusts who have scored 100 per cent and are joint top scoring nationally.

BSMHFT's overall organisational scores are an increase on its 2016 scores for 5 of the 6 categories (Cleanliness, Privacy, Dignity and Wellbeing, Condition, Appearance and Maintenance, Dementia and Disability).

- BSMHFT is in the **top scoring 4%** of NHS Trusts for **Cleanliness.**
- BSMHFT is in the **top scoring 9%** of NHS Trusts for **Food & Hydration.**
- BSMHFT is in the **top scoring 10%** of NHS Trusts for **Privacy, Dignity & Wellbeing.**
- BSMHFT is in the **top scoring 14%** of NHS Trusts for **Condition, Appearance & Maintenance.**
- BSMHFT is in the **top scoring 8%** of NHS Trusts for **Dementia (Environment).**
- BSMHFT is in the **top scoring 26%** of NHS Trusts for **Disability (Environment.**

	BSMHFT Overall Score 2017	National Average Score	BSMHFT's score compared to other trusts
Cleanliness	100%	98.4%	Joint top score in the top 4% of all NHS trusts
Food and Hydration	96.06%	89.7%	in top 9% of all NHS trusts
Privacy, Dignity and Wellbeing	94.12%	83.7%	in top 10% of all NHS trusts
Condition, Appearance and Maintenance	97.71%	94.0%	in top 14% of all NHS trusts
Dementia (Environment) (introduced 2015)	93.64%	76.7%	in top 8% of all NHS trusts
Disability (Environment) (introduced 2016)	89.86%	82.6%	in top 26% of all NHS trusts

BSMHFT's 2016 PLACE Scores					
99.60%	96.87%	93.90%	96.69%	84.83%	89.01%
BSMHFT's 2015 PLACE Scores					
100%	96.70%	94.25%	95.62%	94.65%	
BSMHFT's 2014 PLACE Scores					
99.67%	96.09%	91.82%	97.74%		
BSMHFT's 2013 PLACE Scores					
98.77%	92.34%	91.83%	91.43%		

Effective information in Accident and Emergency departments

The Rapid, Assessment, Interface and Discharge (RAID) team is a specialist multidisciplinary mental health service. Their remit is to work with people with mental health or substance misuse needs who access accident and emergency (A&E) departments in hospitals in Birmingham and Solihull (across five hospital sites; Heartlands, Good Hope, Solihull, UHB and City). The service believes that supporting patients' mental health is of utmost importance because;

- 1 in 4 people will experience some form of mental health condition in their lifetime.
- Mental health disorders such as depression, anxiety, alcohol addiction and memory problems are very common in general hospitals. However these are often not recognised or treated.
- 2 in 3 older adults admitted to a general hospital have or may develop mental health issues during their admission.
- Untreated mental health issues can lead to longer hospital admissions and poorer overall physical health in hospital inpatients.

However from their interactions with patients and carers, the RAID team recognised that there was a lack of information, around mental health services or available support, located within the five acute hospital sites. Therefore in February 2018 a short trial was undertaken with the placement of a range of resource leaflets in public display racks in acute trusts. These covered information about; MIND, Homeless Mental Health Services, Domestic Violence support, Birmingham Healthy Minds psychological therapies service, Cruse Bereavement Care as well as information regarding access to alcohol services.
The trial was deemed a huge success and the RAID team has now decided to ensure these leaflets are available in all five hospital sites in which they are based. To support this nominated leads have been identified to regularly monitor the displays. In addition the service has sourced a range of Trust self-help leaflets about common mental health conditions, treatment options and interventions.

These include:

- Anxiety
- Depression
- Stress
- Self-harm
- Sleeping Problems
- Eating Disorders

These are now available to service users following RAID assessment, dependant on their need.

Experience

The Trust identified the following key indicators for monitoring the quality of service user and carer experience. These were identified in the previous report and following review, they were still deemed to be a priority.

	2015/16	2016/17	2017/18
Patient survey 'do you know who to contact out of office hours if you have a crisis?'	58% (69%)	57% (69%)	60% (71%)
Number of complaints received	131	157	164
Timeliness of complaints	99%*	100%	100%
% of dissatisfied complainants	33 – 25%	24 returned - 15.28%	11 returned - 6%
Number of referrals to the Ombudsman	8	5	5
Number of PALS contacts/resolution	906	885	934
FFT score	88%	86%	87%

(national benchmark figure)

There have been no changes in the way the data has been calculated.
Data source for the patient survey is the National Patient Survey Results, using national definitions, timeliness of complaints is our ECLIPSE reporting system for complaints and for CPA reviews is our KPI report on INSIGHT, our internal reporting system.

The NHS Friends and Family Test (FFT)

Across the year we have adapted the way we do things to improve our performance in our Friends and Family Tests. Our Business Apprentice for Recovery and Patient Experience offers resources and quantities of supplies (including clipboards to present the FFT postcard in waiting rooms), which has proven to increase completed surveys. We also have a new checklist for teams ordering all service user and carer information resources.

Patients who would recommend the trust to their family or friends

The Trust's score from a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

Friends and Family Test Survey	Responses			
	Q1	Q2	Q3	*Q4
Extremely Likely	988	658	890	511
Likely	485	363	455	337
Neither Likely or Unlikely	83	42	70	57
Unlikely	38	34	39	37
Extremely Unlikely	46	40	58	42
Don't know	34	15	42	25
Total Responses	1674	1152	1554	1009
Percentage Recommended	88%	89%	87%	84%

We use the 'You Said, We Did' approach for all completed actions, as the visibility of service improvements is very important. We have created displays at many sites to demonstrate we are listening to feedback and actively using it. Regular compliments are received through the FFT feedback and we post these every week on Connect. We also add compliments that wards have received directly, as well as those posted on NHS Choices, Patient Opinion and Healthwatch online sites.

Actions from the FFT feedback include:

- flexibility for receiving depot medication, a new clinic has been introduced on a different day
- Northcroft has a large waiting area and a high number of patients pass through this area therefore more racks for leaflets have been purchased
- Ardenleigh has organised for a hairdresser to regularly attend the wards
- Ardenleigh has added more flexibility to the menu to enable patients to order different foods
- pharmacy to attend user forums at Small Health and Zinnia for patient to directly ask about medications and side effects.

SeeMe – our service user engagement team

My experience, my service, my recovery

Our SeeMe Team uses a well-developed feedback tool to record all evidence received from patients about the experience of our services. The report has been structured so that information can be extracted for SeeMe workers who can cross check actions have been competed when promised by staff to resolve issues. The data can also be compared with data by team for FFT, complaints, and PALS.

A dashboard has been produced which is offered to all local clinical governance committees, so that they can see trends and quantities of FFT feedback in addition to PALS and complaint information, local CGCs can use this information to focus actions across their services.

A new 360 degree feedback tool has been introduced so that team managers can give feedback of the effectiveness of patient experience on their wards, this ensures a 'buy in' from staff teams to ensure that improved patient experience is being delivered.

The SeeMe team has introduced the following:

- Team managers have been to see local communities to help them understand where service users seek help and support. This includes mosques, the Somali community centre and a local charity.
- New Recovery College course around deaf awareness and signing skills has been introduced in response to service users at the Barberry centre who expressed how difficult and isolating it is when people can't communicate with them or understand their needs.
- Conflict resolution meetings have been introduced weekly on a ward where there were difficult relations between service users and service users and staff. The meeting allows frustrations to be aired and direct input from the consultant to address conflict before it disrupts the ward routine.
- Experts by experience who are involved in the Recovery College, attended the Zinnia centre user forum to discuss the difficulties of discussing sexuality in Asian communities, this allowed a full debate about equalities being available for everyone across the protected characteristics.

The Trust has introduced its own advocacy service, funded by NHS England for Forensic patients, BCA independent and advocacy service. The independent work alongside SeeMe workers provides a one to one service to all Forensic inpatients so that they can be accompanied to MDTs and other meetings with professionals. They also help the patients with other problems relating to life on the ward, families and the outside world when preparing for discharge. Although the advocates cannot give welfare advice they are seeking to help through teaching service users how to empower themselves and learn how to complete the forms.

Complaints investigations – highlights and challenges

Our Customer Relations process received positive feedback in the CQC report March 2017 stating: "The Trust's approach to managing and investigating complaints was effective and confidential involving a patient experience team, patient advice and liaison service (PALS) team. The organisation disseminated lessons learned from complaints through a process that included the circulation of a newsletter to all staff and through team meeting discussions."

Our Customer Relations PALS service strives to resolve concerns at the earliest possible opportunity, working closely and collaboratively with clinical colleagues within services in order to do this. This work continues diligently behind the scenes. The cases that we cannot resolve may become formal complaints.

PALS has attempted to resolve 934 cases during 2017/18. We can see the cases where this resolution process has failed, in that, we have received 164 formal complaints registered for 2017/18, this is an increase of seven from 2016/17.

During the first part of the year the continued improvement in the timeliness of complaint responses with 100 per cent of complainants receiving a written response to their complaint within the agreed response time was evidenced. Towards the end of the year, although we have still maintained our 100 per cent response time, we have experienced capacity challenges for investigators which has meant the Customer Relations Team has had to intervene and extend an increasing number of complaint responses.

Nonetheless, the average length of a complaint from registration to closure during 2017/18 was 34.1 days. During 2016/17 the average was 38.7 days.

We have continued to see a significant reduction in the number of complainants returning to us after they have received their response. When complainants do come back, we now undertake a critical assessment of their complaint response to see if there is anything more we can do, or anything more we can put in place. This process is completed in a more efficient time than previously, so complainants are not kept waiting for a second response. We have continued to deliver regular complaints training sessions, or refresher training, to provide updates to staff on the changes to the September 2016 policy during 2017/18. This has increased the pool of independently trained investigators who can undertake a complaint investigation. This also exposes those staff completing investigations to both good and bad practice elsewhere in the Trust and identifies potential remedies for those experiences that we see could be improved. We are now in the early stages of reviewing the policy once again, to reflect the close working we are undertaking with the Serious Incidents team, for the overall benefit of service users and their families. We plan to consult on this new draft policy widely, including with service users and carers.

The feedback questionnaire we introduced during 2016/17 has had an overall poor response from complainants. We are therefore considering a different method for people to feedback how we are doing overall whilst dealing with their concerns. This is in the early stages of development and will be piloted during Quarter 2/3 2018/19.

Finally, we are looking to introduce regular feedback of themes of complaints to a forum of service users, volunteers and carers through working closely with the Patient Experience team. It is to be agreed at what stage this will be taking place during 2018/19, but early discussions are already underway.

Secure Care – improving patient experience

The Men's Secure Service based at the Tamarind Centre held an event on 10 October 2017 to celebrate the 30th anniversary of Black History Month and World Mental Health Day. Service users researched inspirational personalities from Black, Asian and Minority Ethnic communities and gave presentations to attendees. All participating service users received certificates and the best presentation received an award to share with their respective ward. External organisations also attended, for example Rap poet Richard Grant, who performs under the alias Dreadlock Alien, hosted the event and Calvert Lawson, an African percussionist, performed live drumming with the service users.

Many of the service users at Tamarind have been within secure services for a very long time and not all of them have been granted leave out into the community. Therefore the service understands the importance of bringing the community into the unit to support their recovery. What this event uncovered was the amount of talent amongst the service users at Tamarind and how the service can incorporate the arts to help service users express themselves and help them on their journey to recovery. This drove the service, led by the Advanced Nurse Practitioner (ANP) for Risk and Security, with the support of Kurly McGeachie, a specialist poetry/lyric workshop facilitator, to submit a project bid as part of the Trust's Dragons' Den initiative. Dragons' Den gives people a chance to make a bid to pitch a service improvement, innovation or new idea to a Dragons' Den panel to get the resources, support, expertise or funding needed to make a change that makes a difference for service users. The project that was pitched focused on the creation of a programme designed to help people articulate their feelings and concerns to help manage agitation through the use of poetry and rap.

During the pitch, the ANP for Risk and Security explained that many service users have had negative experiences which impacts on their ability to express emotions in a very positive way. Poetry and rap is a different media that can help convey that message to others. This activity will benefit both staff and service users as there will be shared learning in a creative way. There will be a tangible end product as service users will be able to display their work and be given an opportunity to showcase it. This activity will aid their recovery and give them a positive experience by unlocking their potential.

The panel chaired by a Non-executive Director, Executive Medical Director and Executive Director of Strategic Partnerships agreed to fund a 12 week programme and also encouraged the involvement of the Community Engagement Team to expand the programme into the wider services outside of Tamarind. It is hoped that the service users at Tamarind will be able to showcase their work at their Family and Friends event which is planned for later in the year. Additionally the Quality Network is holding a service user engagement event for which they are seeking presentations – the service is eager to put forward the work of the service users to demonstrate their skills and abilities to wider communities.

HMP Birmingham – better prisoner engagement

The healthcare services within HMP Birmingham have been working on better prisoner engagement in order to improve the services they deliver to inmates. This has involved the inclusion of prisoners, who are healthcare representatives, at quarterly clinical governance meetings, where the focus of the meeting is on service user experience. Staff have found it invaluable to hear direct experiences of healthcare services from the perspective of inmates. Additionally, prisoners in attendance have regularly thanked healthcare staff for listening to their concerns and taking their ideas forward. Outlined below are a few examples of issues or achievements raised by prisoners and the subsequent discussion taken place by the Clinical Governance Committee.

Prisoners are not always receiving their appointment slips or are receiving them late, resulting in missed healthcare appointments. The healthcare representatives reported that slips are often sitting in offices and not being picked up by officers. The Committee discussed a proposal of making appointment slips confidential, i.e. not stating what the appointment is for, which will allow for healthcare representatives to hand these slips out instead.

This is something the healthcare representatives were very keen and willing to do. Prisoners will then be able to access one of the kiosks if they wanted to confirm what their appointment is for.

There can be long waiting times to access secondary mental health services. The prisoner healthcare representatives noted that several prisoners have reported that the service is brilliant once they have been seen and they are very satisfied with the care received, but it can take a long time to be seen. The Head of Healthcare is looking at a new model of working for mental health services within the prison as the majority of prisoners do not need to access an enhanced secondary mental health service. Instead there is a need for a more 'front end' primary care service offering quick therapies such as talking therapies which at present is not provided.

A business plan is being developed for a telephone support line for inmates which will be facilitated by Mental Health Matters. The prisoner healthcare representatives described how the idea for the phone line originated from the Mental Health First Aid training delivered within the prison and the absence of useful external services that prisoners can contact whilst in the prison. Mental Health Matters will not only be providing a telephone support line, but they also will offer an aftercare package for prisoners once they are released and produce reports detailing the level of contact made between prisoners and the service. The number for the support line will feature on individual PIN numbers for inmates and they will be able to access the service between 6pm and midnight, seven days a week. This initiative may also highlight a gap and give way to a potential business case for services that are currently unavailable to prisoners who do not meet the threshold for secondary mental healthcare. Personal thanks were given to the prisoner healthcare representatives for their involvement in the business care, as it was recognised that this project is going to be of value to the whole of the prison population.

A couple of the prisoners have developed their own Positive Mental Attitude Group where attendees have opportunities to share their own experiences of mental health. Guest speakers have attended the meetings and topics covered have included: just a thought (mind consciousness and thought), a lived experience of self-harm and recovery, and a mindfulness session. A member of this group achieved second prize in a prison paper competition writing about the development of Mental Health First Aid training within the prison and the aims and aspirations of the Positive Mental Attitude Group.

Annex one

Birmingham and Solihull Mental Health NHS Foundation Trust

Quality Account 2017/18

Statement of Assurance from NHS Birmingham and Solihull CCG, May 2018

1.1 NHS Birmingham and Solihull Clinical Commissioning Group, as coordinating commissioner for Birmingham and Solihull Mental Health NHS Foundation Trust welcomes the opportunity to provide this statement for their 2017/18 Quality Account.

1.2 A draft copy of the quality account was received by the CCG on the 11th April 2018 and the statement has been developed from the information presented to date. It was noted that the draft version contained some data gaps and hence the CCG has not been able to validate all of the information the draft Quality Account contained, the Trust has however provided assurance that they will be populating these data gaps in the final published edition of the Quality Account.

1.3 The formatting and layout of the Quality Account is generally considered to be user-friendly, containing information on performance against each of the priority improvement goals for the organisation. However there is some terminology contained within the document which could be explained more fully to assist the general public to fully understand such issues as Safewards, restrictive interventions and SeeMe workers.

1.4 In 2017/18 the Trust set itself 10 goals achievement of which has been mixed; notable success has been achieved in

1.4.1 Goal 3: 'To reduce the number of incidents resulting in harm to our service users' - The review and benchmarking with similar trusts and actions taken by the Trust to review and reduce harm levels of incidents is really positive step. It's encouraging to see this process is making a difference;

1.4.2 Goal 4: 'we will have a strong and safe approach to the management of leave for detained service users with a reduction in the number of detained patients who fail to return from section 17 leave' and

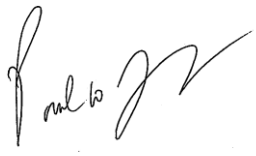
1.4.3 Goal 6: 'Families and carers have a positive experience and feel involved in and supported by out services'. We have received first hand positive feedback from service users about the recovery college initiative.

1.5 Where goals have not been achieved actions have been identified in the narrative to explain how the work will continue.

1.6 For 2018/19 the Trust has identified five goals through internal consultation; the Commissioner is pleased to note that work on reducing mortality and embedding a culture of least restrictive practices feature in the quality improvements for the coming year.

1.7 As commissioners, we have worked closely with the Trust over the course of 2017/18, meeting regularly to review the organisations progress in implementing its quality improvement initiatives. We are committed to engaging with the Trust in an inclusive

and innovative manner and are pleased with the level of engagement from the Trust. We hope to continue to build on these relationships as we move forward into 2018/19.



Paul Jennings
Chief Executive Officer

healthwatch Birmingham

4th May 2018

Statement from Healthwatch Birmingham on Birmingham and Solihull Mental Health Foundation Trust Quality Account 2017/18

Healthwatch Birmingham welcomes the opportunity to provide our statement on the Quality Account for Birmingham and Solihull Mental Health NHS Foundation Trust. We are pleased to see that the Trust has taken on board some of our comments regarding the previous Quality Account. For example, the Trust has:

- Given some examples of patient experience and feedback, and how these are used to develop solutions that improve the quality of services.
- Demonstrated how it communicates with service users and families following the use of their feedback and experiences.
- Provided details of how they will address poor quality of care.

Patient and Public Involvement

It is positive to read how the Trust has involved service users in various activities over the 2017/18 period. We note that the Trust has adopted recommendations from the CQC on Positive and Pro-active Care, in order to address physical risk and patient safety concerns. We are happy to learn that the Trust's Positive and Proactive care Panel includes a service user representative, and the panel collects data and experiences from service users and staff. It is positive to see examples of changes that have been informed by service user feedback. As the work of the panel continues, the Trust should consider using feedback from staff and service users to understand and identify groups who are most likely to be restrained, as the use of prone restraints have not improved over the years. The CQC has found staff are more likely to restrain women (particularly young women) and black people. Understanding the underlying causes for restraints generally is useful, but also understanding this from the perspective of different groups will help the Trust develop strategies that are more appropriate.

In our response to the 2016/17 Quality Accounts, we expressed concern about the lack of involvement of service users and carers in various reviews the Trust carries out. We are pleased that one of the emerging themes following a review into eight avoidable deaths was the recognition that the Trust could learn from 'improved family and carer involvement and engagement'. We commend the Trust for publishing a 'learning from deaths policy', which clearly outlines how the Trust should involve families and carers when the death of a loved one occurs. Involving families and carers in case reviews and investigations offers a more rounded view and understanding of patient experience. We would like to read in the 2018/19 Quality Accounts, how families and patients have been involved in various stages of

case reviews and investigations. In addition, how the Trust weights families and patients views, compared with how they weight the views of clinical staff.

Regarding the Trust's patient experience scores in the National Community Mental Health Survey, we note that the Trust has failed to achieve its goal of improving these scores. However, we welcome the initiatives being implemented in response to the results of the patient survey.

Firstly, the review of care planning through the Clinical Development Programme. We note that three clinical teams identify what they perceive stands in the way of delivering care and supporting initiatives to remove barriers. Healthwatch Birmingham believes that this is an opportunity for the Trust to incorporate into this process, discussions with service users on the specifics of their experience. This will help the Trust to ensure person-centred care.

Secondly, the use of focus groups with service users about crisis planning, and what they would like in them is a useful approach. Focus group discussions will help the Trust understand service user experiences when they are in a crisis; pinpointing areas that need change or understand where services are working well. We would like to read in the 2018/19 Quality Account the impact these initiatives have had on patient experience scores.

At Healthwatch Birmingham, we believe that demonstrating to patients how their feedback is used to make changes or improvements shows service users and the public that they are valued in the decision-making process. Consequently, this has the potential to increase feedback. We note that the Trust is using various ways to communicate with staff and service users how their feedback is used to make changes. We welcome the use of roadshows, and displays at various sites to demonstrate that the Trust is listening and actively using feedback. We particularly welcome the development of the new 360 degree feedback tool, and are pleased that this enables team managers to give feedback on the effectiveness of patient experience on their wards. We believe that this is quite an innovative way for the Trust to gain buy-in from staff to the importance of using patient experience and feedback to improve services. We look forward to reading in the 2018/19 Quality Accounts the impact of this across the Trust.

Ensuring that health and social care organisations are addressing health inequality is a key priority for Healthwatch Birmingham. We are pleased to see how the Trust is engaging with local communities from different ethnicities and those for whom English is not their first language. We note the introduction of courses around deaf awareness and signing skills introduced in response to service user's feedback at Barberry centre.

Complaints

In our response to the Trust's 2016/17 Quality Accounts, we asked to see examples of how the Trust learns from complaints, and consequently how the quality of

service and access to the complaints process is improved. We welcome that the Trust is demonstrating that it is learning from complaints. In particular projects being implemented to ensure that new families and carers have a positive experience and feel more involved and supported by the Trust's services. We note the Carers Assessment project, and the resulting Trust carer's assessment that has been included on the patient information system. In addition, the production of a 'caring into the future booklet', which ensures consistency of care and continued involvement of families when the carer is not available.

Care Support Plans (CPA)

In our response to the 2016/17 Quality Accounts, we expressed concern that, whilst the percentage of completed CPA reviews was increasing, not all service users that should have, had a completed care plan, completed risk assessment and a health and social care assessment. Based on the data provided in the 2017/18 Quality Account, the situation has not changed. For those on a CPA (2017/18), only 82.4% had a completed CPA care plan, 81.9% had a risk assessment done, and 81.5% had a health and social care assessment. A reduction on the 2016/17 Quality Accounts percentage, which was 88.3%, 86.3% and 86.9% respectively. Whilst we commend the Trust for improving the percentage of CPA reviews carried out from 92% in 2016/17 to 97% for 2017/18, the above reductions represents a variability in care. Those with a completed assessment will tend to receive care that is tailored to their needs. Equally, failure to carry out assessments might contribute to the Trust not meeting other targets such as suicide and mortality rates.

In addition, Healthwatch Birmingham is concerned that the quality of care plans are inconsistent and there is no consistent approach to the recording of care plan documentation – according to audits and the CQC inspection. These indicated that:

- The Trust does not always include statements in care plans when prescribing high dose antipsychotic drugs for all acute and psychiatric intensive care patients.
- The Trust does not always update patient's care plans following episodes of rapid tranquilisation incidents.
- The standard is not being met for updating care plans within a week of an incident occurring and updates to care plans on patient preferences and include details of management of future incidents.
- The standard is not being met for the provision of injections (e.g. haloperidol) with heart monitoring information.
- The quality of care plans are inconsistent at point of discharge.

We recognise that the Trust has initiated a number of actions in relation to these concerns. For instance, care planning training has been extended to Associate Nursing Staff and student nurses; and a listening in action engagement event has taken place. We note that, based on this event, the Trust will be implementing various actions from April 2018. We would like to read in the 2018/19 Quality Accounts, the impact these actions have had on the quality of care plans and continued service user involvement in the care planning process.

Communication with General Practitioners

In our response to the 2016/17 Quality Accounts, we observed that the Trust had failed to meet its target to improve communication with GPs; to ensure timely information exchange. We are concerned that the 2017/18 Quality Accounts still shows that targets set under this goal have not been achieved and are way below the set target. For instance, regarding letters sent to GPs following a CPA review and routine outpatient appointment, only achieved to send 55% for patients on CPA and 35% for patients on care support against a target of 90%. Equally, only 12% discharge summary from inpatient stay and 0% for home treatment team episodes were sent to GPs. This means that there is a delay in other health professionals receiving important information about diagnoses, prescriptions and ongoing monitoring and treatment. All of which can have a negative impact on patients. We note that this has not been carried into the 2018/19 Quality Account priorities. We ask the Trust to consider reporting on the progress on this in the 2018/19 Quality Account.

The Trusts Priorities for 2018/19

Similar to our comments to the 2016/17 Quality Accounts, we are concerned that consultations, on the quality priorities for 2018/19, have not included service users, carers and the public. Although we commend the Trust for drawing from various sources of feedback (from Clinical Governance Committee; Integrated Quality Committee; and Council of Governors) to develop its priorities for the 2018/19 period, it is still not clear how the Trust uses the public and service user feedback to inform its priorities. Healthwatch Birmingham has taken note of the Trusts priorities for 2018/19 relating to patient and public engagement.

We believe that continued focus on the involvement and engagement of families and carers when undertaking various activities, such as risk assessments and care planning, is important. As are plans to make improvements to Question 37 of the National Community Mental Health Service User Survey. So that the Trust can better understand whether mental health services are effectively involving families and carers. In particular, we are pleased to see that the Trust plans to scope all opportunities for co-production and family, carer and service user involvement from ward to board.

Healthwatch Birmingham believes that the above scoping exercise presents an opportunity for the Trust to partner with Healthwatch Birmingham through our ‘Patient and Public Involvement Quality Standard’. Healthwatch Birmingham and the Trust have had discussions about partnership working, which we would like to develop further. Healthwatch Birmingham is running various projects to support providers in Birmingham to meet their statutory role of consulting and engaging with patients and the public. Consequently, we are helping Trusts ensure they are using public and patient feedback to inform changes to services, improve the quality of services and understand inequality in access to services and health outcomes. We have worked with some Trusts to review their patient and public

involvement processes (PPI), identify areas of good PPI practice and recommend how they can make PPI practice more effective. As the Trust scopes for opportunities for co-production and engagement, it is an opportune time for the Trust and Healthwatch Birmingham to work together to develop a strategy for PPI and build on best practice.

To conclude, Healthwatch Birmingham would like to commend the Trust for taking action in response to our comments on the 2016/17 Quality Accounts. It is positive to see how the Trust uses feedback to develop actions and improve services. As well as using patient experience, feedback and insight to understand and address issues of health inequality. It is our wish to see further improvements in this area. We would welcome the opportunity to explore how we can support the Trust to improve this aspect of their work in the year ahead.

Andy Cave
CEO
Healthwatch Birmingham

Overview and Scrutiny Committee

The Birmingham Health and Social Care Overview and Scrutiny Committee has indicated that it is not in a position to provide a statement on the Birmingham and Solihull Mental Health Foundation Trust draft Quality Report 2017-18

Statement from the Council of Governors – Quality Account 2017/18

Throughout 2017/18, we (the Council of Governors) have continued our work as outlined in previous Accounts, providing input and advice to the Trust Board individually and through the Council of Governors meetings.

As a Council of Governors we set challenging targets for quality improvement for this year which represented year 1 of the delivery of a 3 year quality strategy that we helped to develop. We are pleased to see that we have made improvements against our previous year's performance across a number of the goals that we set and are particularly pleased with the reduction of physical assaults that have taken place on our hardworking and committed staff. We understand the importance of physical health within the mental health arena and can see that our clinicians have very much progressed this agenda during the year in relation to the recording of cardio metabolic indicators. We are also pleased to see a reduction in the number of patients who have fallen within our Dementia and Frailty services, however we note that we have not achieved our overall target reduction levels due to patients falling in other areas of the Trust such as our acute services. Our incident reporting levels remain within the median seen across mental health services nationally and our levels of harm are lower than seen in many other mental health organisations. Whilst we recognise that we have not achieved all of the target levels that we set, the improvements are nevertheless commended particularly given that we increased the number of inpatient beds that we provide part way through the year. We are pleased to see that the number of incidents of prone restraint have reduced in comparison to 12 months ago, however we know that we are a national outlier in this area and we have confidence that our positive and proactive care expert panel are leading some improvement work in this area which will flow through into 2018/19. During the year we have seen the Trust Board govern some important enablers that will allow continued improvement beyond 2017/18. This includes the procurement of a partner to work with the Trust in Quality Improvement and also the early development of integrated reporting.

We are confident that the Trust is learning from incidents and complaints and were pleased to see the positive remarks made about learning from such issues in all of our published CQC reports during 2017/18. We have been able to see how our learning from serious incidents has changed the way that we do some things in the Trust including therapeutic observation practice. Historically we could see that the completion of paper forms was not the most robust way of recording observation of patients and as a result an app has been developed and implemented across the Trust with in-built alert and audit systems to ensure timely practice and recording. Governors welcome these improvements in safety and look forward to seeing the impact of these initiatives in the forthcoming year.

Governors remain concerned that the number of prone restraints reported in the Trust is much higher than those seen nationally within other mental health providers. We have therefore selected the quality goal of 'least restrictive practice' as the Quality Goal indicator for external audit.

During the year individual Governors have played a particularly strong role in the Trust's recovery agenda and have helped to develop our very successful Recovery College, together with the appointment of a number of peer support workers within the organisation.

We have rolled this initiative out to our Solihull community and now have a Recovery College in operation in this area. Service User and Carer Governors are also strongly involved in the work that is being taken forward to enhance the involvement and engagement of families and carers within the organisation and are represented on a range of forums in the Trust that are contributing to this important initiative.

During the year we have seen the Trust move forward with its approach to Learning from Deaths with the implementation of mortality case note reviews to determine whether there were any care factors which could have impacted on the death of individuals. We have a strong Mortality Surveillance Group whose membership includes a representative from our main Commissioner. We have a published Learning from Deaths Policy and have held two masterclasses for clinicians during 2017/18 to ensure that skills are developed in understanding mortality reviews. These have been very well attended and have included presentations from Her Majesty's Coroner in Birmingham.

Governors are at one with the Trust Board in emphasising that excellent patient care must be at the core of any changes which are made. Patient experience at present as measured by the Friends & Family Test is generally good, but there is still room for improvement. In consulting about any proposed changes the Governors will seek to ensure that there is no negative impact on patient experience.

In concluding this statement, the Council of Governors would like to take the opportunity of thanking the Trust for their proactive approach to seeking the views of Council throughout the course of 2017/18 and the opportunities that this has brought about for service improvement, enhanced safety and quality of care.

Changes made in response to stakeholder feedback

The following changes have been made in response to stakeholder feedback:

- SeeMe worker has been defined.
- Restrictive practices has an explanation added.
- Definition included of Safewards.

Annex two

Statement of directors' responsibilities for the quality report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 and supporting guidance
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - Board minutes for the period April 2017 and up to the date of signing this statement;
    - papers relating to the quality report reported to the Board over the period April 2017 to the date of signing this statement
    - feedback from the commissioners NHS Birmingham and Solihull Clinical Commissioning Group dated 10 May 2018
    - feedback from the Council of Governors dated 29 March 2018
    - feedback from Local Healthwatch organisation, Healthwatch Birmingham, dated 4 May 2018
    - Feedback from the Overview and scrutiny committee dated 23 May 2018
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated October 2017
    - the Survey of people who use community mental health services 2017
    - the 2017 National NHS staff survey results from Birmingham and Solihull Mental Health NHS Foundation Trust
    - the Head of Internal Audit's annual opinion over the Trust's control environment dated 19 May 2018
    - The Care Quality Commission inspection report for Specialist community mental health services for children and young people, quality dated 8 March 2018.
- 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.

- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board

23/5/18 .....Date.....Sue Davis CBE, Chair

23.5.18 .....Date.....John Short, Chief Executive

Annex three

Glossary of data referred to in this report

Title of the indicator	Local or national measure	What it measures	Where the data comes from
Do you feel safe on this inpatient unit?	local	This question is asked monthly to 5 service user on every ward	Inpatient Nursing metrics, this data is collected by nurses on the wards monthly
Does the ward feel like a safe place to be?	local	Every patient is given the opportunity to complete this survey on an inpatient ward	real time feedback - inpatient survey
Number of SUs with 5+ incidents of where patient is identified as the aggressor (inpatients)	local	This identifies that service users who in the past month have been the aggressors in an incident	Eclipse – our incident reporting system
Physical assaults on staff (inpatients)	local	The number of physical assaults on staff from inpatient units	Eclipse – our incident reporting system
Physical assaults on patients (inpatients)	local	The physical assaults on patients on inpatient units	Eclipse – our incident reporting system
Number of Bank filled shifts	local	The number of shifts on inpatient units where we had to use bank staff (this is our own internal	Allocate – the staffing systems that manages shifts
Number of Agency filled shifts	local	The number of shifts on inpatient units where we had to use agency staff	Allocate – the staffing systems that manages shifts
Number of unfilled temporary staffing shifts across all operational services	local	The number of shifts that we were unable to fill with any staff	Allocate – the staffing systems that manages shifts
Number of vacant clinical posts in service areas	local	The number of posts that are currently not filled by a permanent member of staff	Electronic staff record
Never events	National	Serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers	Eclipse – our incident reporting system
Serious incidents reported (not As and Gs, include SIs that were subsequently downgraded):	local	An incident that occurred that resulted in death, harm, the ability to deliver a service, abuse, loss of confidence in a service or a never event	Investigation team

Title of the indicator	Local or national measure	What it measures	Where the data comes from
Riddor reportable incidents	National	All work related injuries or deaths that result in incapacitation for more than 7 days or being taken directly to hospital for treatment	Eclipse – our incident reporting system
Recurring incidents: Patients with 3+ falls identified in month	local	A patient who has fallen 3 or more times in the preceding month	Eclipse – our incident reporting system
Total patient restraints	local	The number of incidents that identified a patient was restrained	Eclipse – our incident reporting system
Patient restraints including a position of prone	local	The number of incidents that identified a patient was restrained and during that restraint the patient was held face down	Eclipse – our incident reporting system
ICR completion across the Trust	local	The completion of the basic core documents for patients being managed under CPA	Report on our information system, INSIGHT which uses data from RiO, our electronic care record
% of service users who confirm they have been offered a copy of their care plan	National	If service users confirm that they have been offered a copy of their care plan	real time feedback - inpatient survey
% of service users who have a CPA review every 6 months	local	If service users have had their care reviewed with a CPA review in the last 6 months	Report on our information system, INSIGHT which uses data from RiO, our electronic care record
Follow-Up within 7 days of Discharge from Inpatient Care	National	The percentage of patients being treated under the Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care.	Report on our information system, INSIGHT which uses data from RiO, our electronic care record
Home Treatment Team Gatekeeping of Admissions to Acute Wards	National	The percentage of admissions to acute wards for which a Crisis Resolution / Home Treatment Team acted as a gatekeeper.	Report on our information system, INSIGHT which uses data from RiO, our electronic care record
Readmissions within 28 Days	National	The percentage of admissions to Trust hospitals of patients aged 0 to 15 and 16 or over	Report on our information system, INSIGHT which uses data from RiO, our electronic care record
Patient Experience of Community Mental Health Services	National	Answer to the question 'Overall the rating of your experience was? 0-10 (0 = poor, 10 = very good)	Community patient survey

Title of the indicator	Local or national measure	What it measures	Where the data comes from
Early intervention in psychosis (EIP): People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral Ⓐ	National	The percentage of patients with a referral for first episode of psychosis treated with a NICE-approved package of care within two weeks of referral	Report on our information system, INSIGHT which uses data from RiO, our electronic care record
Inappropriate out of area placements for adult mental health services (average bed days per month) Ⓐ	National	The total number of bed days patients have spent inappropriately out of area (stated as the monthly average)	Report on our information system, INSIGHT which uses data from RiO, our electronic care record
Patient Safety Incidents	National	The number and rate of patient safety incidents reported within the Trust, and the number and percentage that resulted in severe harm or death.	Eclipse – our incident reporting system
Staff Family and Friends Test	National	The percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends, as reported in the NHS National Staff Survey.	Independently managed staff survey
100% of CPA patients having formal review in past 12 months (new definition for 2012/13)	National	If service users have had their care reviewed with a CPA review in the last 12 months	Report on our information system, INSIGHT which uses data from RiO, our electronic care record
Minimising delayed transfers of care - (Including social care delays)	National	The number of acute patients per day whose transfer of care was delayed	Report on our information system, INSIGHT which uses data from RiO, our electronic care record
Admissions to inpatient services having access to crisis resolution home treatment teams	National	The number of admissions to wards whose care was managed by a crisis resolution home treatment team	Report on our information system, INSIGHT which uses data from RiO, our electronic care record
Meeting commitment to serve new psychosis cases by early intervention teams based on trajectories agreed with Commissioners.	National	Have we seen the number of new psychosis cases that we agreed to see	Report on our information system, INSIGHT which uses data from RiO, our electronic care record
MHMDS Data completeness identifiers	National	Is the basic data of NHS number, Date of birth, postcode, gender, GP registered code and Commissioner code completed in our care records	Report on our information system, INSIGHT which uses data from RiO, our electronic care record

Title of the indicator	Local or national measure	What it measures	Where the data comes from
MHMDS Data completeness outcomes: % service users on CPA in last 12 months having: employment status recorded accommodation status recorded a HONOS assessment	National	Have these 3 fields been completed for our patients who are managed under CPA	Report on our information system, INSIGHT which uses data from RiO, our electronic care record
Access to healthcare for people with learning disabilities – compliance against 6 criteria.	National	Meeting the 6 criteria for meeting the needs of people with a learning disability	Report on our information system, INSIGHT which uses data from RiO, our electronic care record
Numbers of Incidents reported	local	The total number of incidents reported	Eclipse – our incident reporting system
Clostridium Difficile Infections	National	The number of toxin positive reportable infections	Figures collected by the Infection Control Team
MRSA infections	National	The number of positive infections	Figures collected by the Infection Control Team
Health and safety training	local	The number of staff who have completed the appropriate health and safety training for their position	Electronic staff record
The management of violence and aggression training – AVERTS 5 day training	local	The number of staff who have completed the appropriate training for their position	Electronic staff record
Completion of risk assessment	local	The completion of the risk screening tool either level 1 or 2 for patients managed under CPA	Report on our information system, INSIGHT which uses data from RiO, our electronic care record
Completion of Summary Assessment (previously known as the Health and social care assessment)	local	The completion of the summary assessment for patients managed under CPA	Report on our information system, INSIGHT which uses data from RiO, our electronic care record
Patient survey 'do you know who to contact out of office hours if you have a crisis?'	National	Answer to the question 'do you know who to contact out of office hours if you have a crisis?'	National Patient Survey
Timeliness of complaints	National	Have we responded to the complaint in the number of days we agreed to do so with the complainant	Figures collected by the complaints department

Annex four

Monitor Criteria for Indicators

Inappropriate Out of Area Placements Ⓐ

The Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:

- Indicator is expressed as the total number of bed days patients have spent inappropriately out of area (stated as the monthly average)
- The indicator considers all adult admissions to acute inpatient services.

- In-area placements are:
  Admissions to a local provider (e.g. inpatient hospital site) within the catchment area of the patient's community mental health team (CMHT).

  Admissions to a local provider, but not within the catchment area of the patient's CMHT, but where the patient's care coordinator is able to visit them as often as stated in the Trust's policy for locally admitted patients.

- Out-of-area placements are:
  Admissions to an inpatient unit at a non-local provider.
  Placements to a local provider, but not within the catchment area of the patient's CMHT, and where the patient's care coordinator is not able to visit them as often as stated in the Trust's policy for locally admitted patients.

- Out-of-area placements are inappropriate when the cause is local unavailability of beds.

- Out-of-area placements may be recorded as appropriate when:
  The patient became acutely unwell away from home.
  There are safeguarding reasons (such as gang-related issues, domestic abuse, or similar).
  The patient is a member of the local service's staff (or has had contact with the service as part of their normal employment).
  The patient chose to be treated out-of-area.
  The patient has offending restrictions on their movement or placement at inpatient wards.

Early Intervention in Psychosis Ⓐ

The Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:

- The indicator is expressed as a percentage of those patients with a referral for first episode of psychosis treated with a NICE-approved package of care within two weeks of referral.
- The numerator includes all referrals to and within the trust with suspected first episode psychosis (FEP) that start a NICE-recommended care package in the reporting period within 2 weeks of referral.
- The denominator includes all referrals to and within the trust with the primary reason being suspected FEP, and that start a NICE-recommended care package in the reporting period.
- The indicator includes referrals from all sources.
- Timing of the referral starts upon receipt of the referral request.
- All referrals under code "01: (Suspected) First Episode Psychosis" are included.
- Patients are recorded as having started a care package if the below apply:
- The referral is recorded as having FEP or suspected FEP following assessment

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

We have been engaged by the Council of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust to perform an independent assurance engagement in respect of Birmingham and Solihull Mental Health NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor:

Specified Indicators	*Specified indicators criteria*
Early intervention in psychosis (EIP); people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE) approved care package within two weeks of referral	NHSI specific criteria (set out within the Trust's Quality Report Annex 4 p192).
Inappropriate out-of-area placements for adult mental health services.	NHSI specific criteria (set out within the Trust's Quality Report Annex 4 p191).

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports for foundation trusts 2017/18" issued by Monitor (operating as NHS Improvement) ("NHSI").

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

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2017/18".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18"; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the financial year, April 2017 and up to the date of signing this limited assurance report;
- Papers relating to quality report reported to the Board over the period April 2017 to the date of signing this limited assurance report;
- Feedback from the Commissioners NHS Birmingham and Solihull Clinical Commissioning Group dated 10 May 2018;
- Feedback from the Council of Governors dated 29 March 2018;
- Feedback from Local Healthwatch organisation, Healthwatch Birmingham, dated 4 May 2018;

- Feedback from Overview and Scrutiny Committee dated dated 23 May 2018;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated October 2017;
- The survey of people who use community mental health services 2017;
- The 2017 National NHS staff survey results from Birmingham and Solihull Mental Health NHS Foundation Trust;
- Care Quality Commission inspection report for specialist community mental health services for children and young people, quality dated 8 March 2018;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 19 May 2018.

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

Our Independence and Quality Control

We applied the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust as a body, to assist the Council of Governors in reporting Birmingham and Solihull Mental Health NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and 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 (Revised)'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and "Detailed requirements for quality reports for foundation trusts 2017/18"and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Birmingham and Solihull Mental Health NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2018:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2017/18".

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP

Birmingham

25 May 2018

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

Report on the audit of the financial statements

Opinion

In our opinion, Birmingham and Solihull Mental Health NHS Foundation Trust's Group and Trust financial statements:

- give a true and fair view of the state of the Group and Trust's affairs as at 31 March 2018 and of the Group and Trust's income and expenditure and cash flows for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18.

We have audited the financial statements, included within the Annual Report and Accounts (the "Annual Report"), which comprise: the Group and Trust's Statement of Financial Position as at 31 March 2018; the Consolidated Statement of Comprehensive Income for the year then ended; the Group Statement of Cashflows for the year then ended; the Group and Trust's Statement of Changes in Taxpayer's Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of the Group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Our audit approach

Context

Our audit for the year ended 31 March 2018 was planned and executed having regard to the fact that the Group and Trust's operations and financial stability were largely unchanged in nature from the previous year. In light of this, our approach to the audit in terms of scoping and areas of focus was largely unchanged.

Overview

- Overall materiality: £4.706 million which represents 2% of total revenue.

- We conducted the audit work on the Consolidated Group financial statements at the Parent Trust's headquarters in Birmingham, which is where the Trust's finance function is based.
- Work was undertaken on the Parent Trust's and subsidiary Summerhill Supplies Limited's financial statements, which together form the Group.
- Our work did not include the Birmingham and Solihull Mental Health NHS Foundation Trust Charity, which is not included in the Consolidated Group financial statements

Our key areas of focus were:

- Management override of controls;
- Risk of fraud in revenue and expenditure recognition; and
- Valuation of Property, Plant and Equipment.

The scope of our audit

As part of designing our audit, we determined materiality and assessed the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain.

As in all of our audits we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

Key audit matters

Key audit matters are those matters that, in the auditors' professional judgement, were of most significance in the audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. This is not a complete list of all risks identified by our audit.

Key Audit Matter	*How our audit addressed the key audit matter*
Management override of controls and risk of fraud in revenue and expenditure recognition *See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to the recognition of income and expenditure and notes 3-6 for further information.* We focused on this area because there is a heightened risk due to the Group being under increasing financial pressure. Whilst the Group is looking at ways to maximise revenue and reduce cost, there is an incentive for management to manipulate the timing of the recognition of both revenue and expenditure. We considered the risk to be manipulation to overstate income and/or understate expenditure to improve the reported position. We also considered revenue recognition to be a risk during the year ending 31 March 2018, in particular the revenue from Clinical Commissioning Groups (CCGs). The service level agreements with CCGs are renegotiated annually and usually consist of the payment of standard monthly instalments and a year-end settlement based on any under or over performance in the year. These are negotiated with the CCGs after the end of the financial year and this process is, therefore, subject to management judgement regarding its value and recoverability. Given these incentives, we focused our work on the elements of income and expenditure that are most susceptible to manipulation. We considered the key areas of focus to be: • non-standard journal transactions; • items of income or expenditure whose value is dependent upon estimates: including provisions, accruals, prepayments and deferred income; • year-end settlements in relation to healthcare income; and • unrecorded assets and liabilities.	**Income from activities** For a sample of healthcare income, we obtained and agreed the income received during the year to a signed contract with the CCGs with no exceptions noted. For a sample of income recognised in relation to under-/over-performance against contract we agreed to activity reports and, where possible, cash movements, with no exceptions noted. We used the mismatches report provided by NHS Improvement to identify any differences between income, expenditure, debtors and creditors reported by other NHS organisations. We then checked that management had investigated all disputed amounts over £300,000. We read correspondence with the counterparties, and then considered the impact, if any, that the remaining disputed amounts would have on the Group's financial statements and determined that there was no material impact. **Deferred income** We agreed a sample of balances to the cash receipts and read the terms and conditions associated with the income to confirm that there was a right to defer the income into future periods and that where income had been deferred there were expenditure plans in place for the income to be spent in future periods. **Prepayments** We traced a sample of prepayments to cash payments and invoices to confirm that the payment had been made before 31 March 2018 and that the goods or services to which the payment relates had not been received by 31 March 2018. **Provisions** We obtained an understanding of the movement for each category of provision and performed testing on a sample of provisions. We then examined the evidence available to support the recognition of the provisions at 31 March 2018. **Accruals** We agreed a sample of accruals back to the supporting invoice received and confirmed that the amounts were correctly accrued. Where invoices had not been received at the time of our audit, we obtained details of how the accrual had been

calculated, what information had been used to form the estimate and where this information had been received from. We then re-performed the calculation.

Journals

We focussed our work on the elements that are the most susceptible to manipulation and selected a sample of manual journal transactions that had been recognised in the financial statements, focussing in particular on those:

- that used unusual account combinations; and
- that were raised by senior members of the finance team.

We traced these journal entries to the supporting documentation.

Other year-end procedures

We tested transactions pre and post year-end, which included credit notes, receipts and payments, and invoices raised and received to confirm that income and expenditure had been accounted for in the correct accounting year.

Our testing did not identify any evidence of fraud or manipulation of the Group's results.

Valuation of property, plant and equipment

See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to Property, Plant and Equipment and note 10 for further information.

Property, plant and equipment (PPE) represents the largest balance in the Group and Trust's Statement of Financial Position. PPE at 31 March 2017 was valued at £190 million for the Group and £91 million for the Trust.

PPE assets are initially measured at cost, with property and land assets subsequently measured at fair value ("market value") once the asset is brought into use.

The Group continued to adopt a Modern Equivalent Asset method as in previous years.

A full valuation of the Group's land and buildings was undertaken by the District Valuer using the Optimised Modern Equivalent Asset method of valuation, which involves a range of assumptions being used. The District Valuer is an external independent valuer of the Group who is a professionally qualified member of the Royal Institute of Chartered Surveyors.

We focused on this area due to the material nature of this balance, and the impact on the financial statements if it were to be materially misstated. The specific areas of risk considered were:

- accuracy and completeness of detailed information on assets provided to the valuation expert, in particular the floor plans on which the valuation is based;
- the methodology, assumptions and underlying data used by the District Valuer and Trust consultants; and
- the accounting transactions resulting from this valuation with a £4.49 million gain charged to the Statement of Comprehensive Income as an exceptional item, and the remaining movement of

We have tested a sample of land and building site plans and asset information held within the Trust's Estates Department. We have understood how the existing estate has been used to develop a new "optimised" estate based on consolidating the existing estate into six hub sites reflecting how future services would be delivered if the entire estate was to be redesigned.

We have assessed the assumptions and estimates used in developing this optimised estate and considered the reasonableness of these using our experience of Trust operations.

We obtained and read the relevant sections of the full valuation performed by the District Valuer. We assessed the assumptions and the estimates used in the valuation and considered the reasonableness of these using our valuation expertise and consideration of wider industry trends.

We checked that the valuation information has been correctly input into the Fixed Asset Register and, consequently, that the accounting treatment has been recorded appropriately in the Group's financial statements.

We inspected the repairs and maintenance expense codes to confirm that there had been no significant alterations to the existing value and use of assets.

£8.7 million recognised in the revaluation reserve.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the structure of the Group, the accounting processes and controls, and the environment in which the Group operates.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

	Group / Trust financial statements
Overall materiality	£4.706 million (2017: £4.617 million)
How we determined it	2% of revenue, consistent with last year.
Rationale for benchmark applied	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £230,000 (Group audit) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which ISAs (UK) require us to report to you when:

- the directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Group and Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Group and Trust's ability to continue as a going concern.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report based on these responsibilities.

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the NHS Foundation Trust Annual Reporting Manual 2017/18 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report set out from page 31, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18, and for being satisfied that they give a true and fair view. The directors are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Auditors' responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditors' report.

We are required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based our on risk assessment, we undertook such work as we considered necessary.

We will prepare an annual audit letter which will cover the Trust's key risks in securing economy, efficiency and effectiveness in its use of resources, how these have been discharged by the Trust, and our actions to review these. The Trust is responsible for publishing this annual audit letter, and ensuring that it is available to the public.

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other required reporting

Opinions on other matters prescribed by the Code of Audit Practice

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2018 is consistent with the financial statements and has been prepared in accordance with applicable legal requirements.

In light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, the parts of the Remuneration and Staff reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018. We have nothing to report as a result of this requirement.

Other matters on which we report by exception

We are required to report to you if:

- information in the Annual Report is:
  - materially inconsistent with the information in the audited financial statements; or
  - apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Group and Trust acquired in the course of performing our audit; or
  - otherwise misleading.
- the statement given by the directors on page 58, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable, and provides the information necessary for members to assess the Group and Trust's performance, business model and strategy is materially inconsistent with our knowledge of the Trust acquired in the course of performing our audit.
- the section of the Annual report on page 38, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.
- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 or is misleading or inconsistent with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
- we have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- we have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.
- we have not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.

Lynn Pamment (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Birmingham
25 May 2018

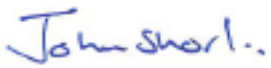
Birmingham and Solihull Mental Health NHS Foundation Trust

Consolidated Financial Statements

31 March 2018

Foreword to the Accounts

These accounts, for the year ended 31 March 2018, have been prepared by Birmingham and Solihull Mental Health NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.



John Short, Chief Executive
23 May 2018

Consolidated statement of comprehensive income for the year ended March 31 2018	Note	March 31 2018 £000 Pre-exceptional Items	March 31 2018 £000 Exceptional Items	March 31 2018 £000 Total	March 31 2017 £000 Pre-exceptional Items	March 31 2017 £000 Exceptional Items	March 31 2017 £000 Total
Operating income	2	235,333	-	235,333	233,758	-	233,758
Operating costs	4	(222,400)	4,368	(218,032)	(223,453)	(33,908)	(257,361)
Operating Surplus / (Deficit)		12,933	4,368	17,301	10,305	(33,908)	(23,603)
Finance Costs							
Finance income	7	46	-	46	38	-	38
Finance costs	8	(5,654)	-	(5,654)	(5,692)	-	(5,692)
PDC Dividend payable		(2,390)	-	(2,390)	(2,045)	-	(2,045)
Net Finance Costs		(7,998)	-	(7,998)	(7,699)	-	(7,699)
Corporation tax expense	29	72	-	72	(3)	-	(3)
Surplus / (Deficit) from Operations		5,007	4,368	9,375	2,603	(33,908)	(31,305)
Surplus / (Deficit) for the year		5,007	4,368	9,375	2,603	(33,908)	(31,305)
Other comprehensive Income / (Expense)							
Will not be reclassified to income and expenditure:							
Revaluation (losses) / gains on property, plant and equipment				8,686			(14,118)
May be reclassified to income and expenditure when certain conditions are met:							
Total comprehensive income / (Expense) for the year				18,061			(45,423)

Statement of Financial Position	Note	Group		Trust	
		March 31 2018	March 31 2017	**March 31 2018**	March 31 2017
As at March 31 2018		**£000**	£000	**£000**	£000
Non-current assets					
Intangible assets	9	**4,226**	1,282	**4,226**	1,282
Property, plant and equipment	10	**190,346**	176,926	**90,985**	99,091
Subsidiary investment	12	**-**	-	**23,036**	23,036
Trade and other receivables	13	**1,512**	1,315	**49,248**	50,872
Deferred tax asset	30	**111**	38	**-**	-
Total non-current assets		**196,195**	179,561	**167,495**	174,281
Current assets					
Inventories	11	**358**	347	**208**	254
Trade and other receivables	13	**14,560**	19,664	**16,059**	21,444
Non-current assets classified as held for sale	10.7	**-**	-	**6,743**	-
Cash and cash equivalents	22	**17,415**	11,151	**16,881**	9,115
Total current assets		**32,333**	31,162	**39,891**	30,813
Current liabilities					
Trade and other payables	14	**(22,880)**	(21,355)	**(22,528)**	(21,014)
Borrowings	16	**(3,608)**	(3,472)	**(4,358)**	(3,472)
Provisions for liabilities and charges	19	**(1,262)**	(1,053)	**(1,262)**	(1,053)
Other liabilities	15	**(4,288)**	(3,974)	**(4,944)**	(4,630)
Total current liabilities		**(32,038)**	(29,854)	**(33,092)**	(30,169)
Total assets less current liabilities		**196,490**	180,869	**174,294**	174,925
Non-current liabilities					
Borrowings	16	**(90,060)**	(93,666)	**(90,060)**	(93,666)
Provisions for liabilities and charges	19	**(1,790)**	(1,874)	**(1,790)**	(1,874)
Other liabilities	15.1	**-**	-	**(1,803)**	(2,459)
Total non-current liabilities		**(91,850)**	(95,540)	**(93,653)**	(97,999)
Total assets employed		**104,640**	85,329	**80,641**	76,926
Financed by (taxpayers' equity)					
Public dividend capital		**101,878**	100,628	**101,878**	100,628
Revaluation reserve		**32,175**	23,489	**4,191**	10,208
Income and expenditure reserve		**(29,413)**	(38,788)	**(25,428)**	(33,910)
Total taxpayers' equity		**104,640**	85,329	**80,641**	76,926

The accounts and the associated notes were approved by the Audit Committee, who have delegated authority from the Trust Board to approve the financial statements. The financial statements were approved on 23 May 2018 and signed on its behalf by:

John Short.

John Short, Chief Executive
Birmingham and Solihull Mental Health NHS Foundation Trust Date: 23 May 2018

Group statement of Changes in Taxpayers Equity For year ended March 31 2018	Total Taxpayers Equity £000	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000
Taxpayers' Equity at April 1 2017 - as previously stated	85,329	100,628	23,489	(38,788)
Prior period adjustment	-			
Taxpayers' Equity at April 1 2017	85,329	100,628	23,489	(38,788)
Surplus / (Deficit) for the year	9,375	-	-	9,375
Revaluation gains/ (losses) on property, plant and equipment	8,686	-	8,686	-
Public Dividend Capital Received	1,250	1,250	-	-
Transfer to retained earning on disposal of assets	-	-	-	-
Taxpayers' Equity at March 31 2018	104,640	101,878	32,175	(29,413)
Taxpayers' Equity at April 1 2016 - as previously stated	130,752	100,628	37,737	(7,613)
Prior period adjustment	-	-	-	-
Taxpayers' Equity at April 1 2016	130,752	100,628	37,737	(7,613)
Surplus / (Deficit) for the year	(31,305)	-	-	(31,305)
Revaluation gains/ (losses) on property, plant and equipment	(14,118)	-	(14,118)	-
Transfer to retained earning on disposal of assets	-	-	(130)	130
Taxpayers' Equity at March 31 2017	85,329	100,628	23,489	(38,788)

Trust statement of Changes in Taxpayers Equity For year ended March 31 2018	Total Taxpayers Equity £000	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000
Taxpayers' Equity at April 1 2017 - as previously stated	76,926	100,628	10,208	(33,910)
Prior period adjustment	-			
Taxpayers' Equity at April 1 2017	76,926	100,628	10,208	(33,910)
Surplus / (Deficit) for the year	8,482	-	-	8,482
Revaluation gains/ (losses) on property, plant and equipment	(6,017)	-	(6,017)	-
Public Dividend Capital Received	1,250	1,250	-	-
Transfer to retained earning on disposal of assets	-	-	-	-
Taxpayers' Equity at March 31 2018	80,641	101,878	4,191	(25,428)
Taxpayers' Equity at April 1 2016 - as previously stated	122,996	100,628	30,972	(8,604)
Prior period adjustment	-	-	-	-
Taxpayers' Equity at April 1 2016	122,996	100,628	30,972	(8,604)
Surplus / (Deficit) for the year	(33,079)	-	-	(33,079)
Revaluation gains/ (losses) on property, plant and equipment	(12,991)	-	(12,991)	-
Transfer to retained earning on disposal of assets	-	-	(7,773)	7,773
Taxpayers' Equity at March 31 2017	76,926	100,628	10,208	(33,910)

Group statement of cash flows For the year ended March 31 2018	Note	March 31 2018 £000	March 31 2017 £000
Cash flows from operating activites			
Operating (deficit) / surplus for the year		17,301	(23,603)
Depreciation and amortisation	4	5,114	3,415
Impairments	4.1	-	33,908
Reversals of impairments	4.1	(4,368)	-
Loss / (gain) on disposal		15	225
(Increase) / decrease in trade and other receivables		3,738	(8,070)
(Increase) / decrease in inventories		(10)	(1)
Increase / (decrease) in trade and other payables		1,647	2,769
Increase / (decrease) in other liabilities		314	(750)
Increase / (decrease) in provisions		126	(1,804)
Other movement in operating cash flows		-	-
Net cash generated from operating activities		23,877	6,089
Cash flows from investing activities			
Interest received	7	46	38
Purchase of intangible assets	9	(3,533)	(63)
Purchase of property, plant and equipment	10	(5,194)	(5,251)
Sales of property, plant and equipment			985
Net cash used in investing activities		(8,681)	(4,291)
Cash flows from financing activites			
Public dividend capital received		1,250	-
Public dividend capital repaid		-	-
Loans repaid to foundation trust financing facility		(2,183)	(2,183)
Capital element of private finance initiative obligations		(1,288)	(1,352)
Interest paid on loans from foundation trust financing facility		(1,628)	(1,680)
Interest element of private finance initiative obligations		(4,058)	(4,011)
PDC dividend paid		(1,025)	(3,623)
Net cash used in financing activities		(8,932)	(12,849)
Net increase/ (decrease) in cash and cash equivalents		6,264	(11,051)
Cash and cash equivalents at 1 April		11,151	22,202
Cash in hand (petty cash)	22	54	39
Cash at commercial banks	22	534	2,036
Cash at GBS	22	16,827	9,076
Cash and cash equivalents at 31 March		17,415	11,151

Notes to the financial statements

1 **Accounting policies and other information**

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2017/18 issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM 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 under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1 Consolidation

Subsidiary entities are those over which the Foundation Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

Birmingham and Solihull Mental Health Foundation NHS Trust has one 100% owned subsidiary, Summerhill Supplies Ltd, which commenced trading on December 1 2012. The amounts consolidated are drawn from the published accounts of the subsidiary for the year ending March 31 2018. The shares held are ordinary and aggregate capital and reserves amount to £20,463k as at March 31 2018 (£21,178k as at March 31 2017). Summerhill Supplies Limited made a loss of £716k in the year (2017: £498k).

All intra-group transactions, balances, income and expenses are eliminated on consolidation. Adjustments are made to eliminate the profit or loss arising on transactions with the subsidiary to the extent of the Group's interest in the entity. Where the subsidiary's accounting policies are not aligned with those of the Trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where the differences are material. There are a number of differences that existed at the reporting date. In accordance with the Group Accounting Manual a separate statement of comprehensive income and statement of cash flows for the parent (the Trust) has not been presented.

The divergence from the GAM that NHS Charitable Funds are not consolidated with NHS Trust's own returns is removed. Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. The Foundation Trust is the Corporate Trustee of Birmingham and Solihull Mental Health NHS Foundation Trust Charity-Caring Minds (Charity number 1098659) and therefore should consolidate its financial statements if this is material to the Foundation Trust. The Foundation Trust has not consolidated its NHS charity on grounds of materiality which is a percentage of (1% or 2%) of income, expenditure, assets or liabilities and so the Charitable Funds statements have not been consolidated into the Foundation Trust Accounts. This will be reviewed each financial year.

The primary statements and notes to the accounts are presented with separate 'Group' and 'Trust' columns. The foundation trust is able to take advantage of an exemption afforded by the Companies Act to omit the statement of comprehensive income for the foundation trust parent if it wishes. As a foundation trust we have taken advantage of this exemption. The Parent company surplus for the year can be found with the financial summary section of the annual report.

1 **Accounting policies and other information (continued)**

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Foundation Trust is contracts with commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on employee benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the year in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the year is recognised in the accounts to the extent that employees are permitted to carry-forward leave into the following year.

1.4 Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme. Employers pension cost contributions are charged to operating expenses as and when they become due. Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Foundation Trust commits itself to the retirement, regardless of the method of payment.

NEST Pension Scheme

National Employment Savings Trust is a defined contribution pension scheme that was created as part of the government’s workplace pensions reforms under the Pensions Act 2008 (as amended by Pensions Act 2014).

1 **Accounting policies and other information (continued)**

1.5 Expenditure on other goods and services

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

1.6 Property, plant and equipment

Recognition

Property, Plant and Equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes;

• it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust;

• it is expected to be used for more than one financial year;

• the cost of the item can be measured reliably;

• individually have a cost of at least £5,000;

• collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

• form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Property assets are measured subsequently at fair value. Assets under the course of construction are subsequently measured at fair value once the asset is brought into use. Equipment is held at cost.

1 **Accounting policies and other information (continued)**

1.6 Property, plant and equipment (continued)

Fair Value is to be determined for Operational Assets under IAS 16. Fair Value has been clarified by HM Treasury as being reflected by "Market Value" with the explicit assumption that "property is sold as part of the continuing enterprise in occupation". The approach is reflected primarily on the basis of Depreciated Replacement Cost (DRC) for specialised operational property and Existing Use Value for non-specialised operational property.

DRC valuations from the District Valuer are prepared using the Modern Equivalent Asset method of valuation in accordance with the requirements of HM Treasury and in accordance with the requirements of the RICS Valuation Information Paper 10.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the Foundation Trust and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives on a straight line basis which is a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. Property, Plant and Equipment which has been reclassified as ‘Held for Sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-statement of financial position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Foundation Trust, respectively.

Revaluation and impairment

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.
Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

In accordance with the GAM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment. An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

1 **Accounting policies and other information (continued)**

1.6 Property, plant and equipment (continued)

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;

• the sale must be highly probable i.e.

  • management are committed to a plan to sell the asset;

  • an active programme has begun to find a buyer and complete the sale;

  • the asset is being actively marketed at a reasonable price;

  • the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and

  • the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

Donated assets

Donated assets are capitalised at their fair value on receipt. The donation is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1 **Accounting policies and other information (continued)**

1.6 Property, plant and equipment (continued)

Private finance initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-statement of financial position' by the Trust. The underlying assets are recognised as Property, Plant and Equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17. The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the effective interest rate for the scheme. The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

The PFI payments which do not meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's Group Accounting Manual (GAM) 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 at fair value in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.
An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the year, and is charged to "Finance Costs" within the Statement of Comprehensive Income. The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ("life cycle replacement") are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

Assets contributed by the Foundation Trust to the operator for use in the acheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Foundation Trust's Statement of Financial Position

1 **Accounting policies and other information (continued)**

1.7 Intangible assets

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

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:
• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
• the Foundation Trust intends to complete the asset and sell or use it;
• the Foundation Trust has the ability to sell or use the asset;
• how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Foundation Trust to complete the development and sell or use the asset; and
• the Foundation Trust can measure reliably the expenses attributable to the asset during development.

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

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

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1 **Accounting policies and other information (continued)**

1.8 Government grants

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

1.9 Inventories

Inventories are valued at the lower of average cost and net realisable value. Average cost is calculated based on the average purchase price of the inventory held. Provisions are made for slow moving, defective and obsolete inventory if considered necessary by management.

1.10 Financial assets, financial instruments and financial liabilities

Recognition

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

De-recognition

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

Classification and measurement

Financial assets are categorised as 'Fair Value through Profit and Loss' or Loans and receivables. Financial liabilities are classified as 'Fair Value through Profit and Loss' or as 'Other Financial liabilities'.

1 **Accounting policies and other information (continued)**

1.10 Financial assets, financial instruments and financial liabilities (continued)

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Foundation Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and 'other receivables'. Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Financial liabilities

All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the statement of financial position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, the Foundation Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly or through the use of a bad debt provision.

1 **Accounting policies and other information (continued)**

1.11 Leases

Finance lease
Where substantially all risks and rewards of ownership of a leased asset are borne by the Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability. The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.12 Provisions
The Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates of -2.42%, -1.85% or -1.56% for 1-5 years, 6-10 years and 10 years respectively in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 0.10% in real terms.

Contingent liability
The Foundation Trust is currently investigating 2 potential injury allowance applications; due to the nature of the injuries these applications may result in a contingent liability.

The Trust is currently in legal discussions regarding RAID Infringement. This matter is going to trial in October 2018 with judgement expected in November 2018.

Contingent asset
Contingent assets (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 the notes to the financial statements where an inflow of economic benefits is probable.
The Trust suffered a fire at one of its leased community buildings (Yewcroft) in January 2016. Discussions are on-going with loss adjustors and the landlord and at this stage estimates of costs incurred are approximately £0.180m which we would expect to be reimbursed through our insurance policy.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 19.1.

1 Accounting policies and other information (continued)

1.13 Non-clinical risk pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Resolution (Formerly NHS Litigation Authority or NHSLA) and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.14 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) net cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. The Department of Health has confirmed that GBS balance are to be used in the PDC dividend calculation and will be calculated on average daily cleared balances in GBS. They have also confirmed that National Loan Fund balances will be treated as part of the GBS balance in the PDC dividend calculation.

1.15 Taxation

Value added tax (VAT)

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

Corporation tax

Healthcare activities of the NHS Foundation Trust are outside the scope of Corporation Tax. Summerhill Supplies Ltd is not a charitable organisation so is liable to corporation tax charges.

1.16 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Group Accounting Manual.

1 **Accounting policies and other information (continued)**

1.17 Critical accounting judgements and key sources of estimation uncertainty
In the application of the Foundation Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources.

The following balances are areas management have made critical judgements and estimates in the process of applying the Foundation Trust's accounting policies and that have the most significant effect on the amounts recognised in the accounts:

- Provisions
  Provisions have been recognised in these accounts for restructuring which relates to the cost of restructuring a service where an obligation exists at the year end; the most significant cost being redundancy and termination payments. Provisions are only recognised after a clear decision has been made to remove a post and the decision has been communicated to those affected. It is likely that these amounts will be settled during the year ended 31 March 2019.

- Property valuations
  The Trusts' land and buildings are valued by external independent valuers. The valuations incorporate professions assumptions to calculate the "Market Value" of the properties; the largest assumptions are made around the value of modern equivalent assets.

- Property useful economic lives
  The Trusts' buildings and equipments are depreciated over their remaining useful economic lives as described in note 1.6. Management assesses the useful economic life of an asset when it is brought into use and periodically reviews for reasonableness. Lives are based on physical lives of similar class of asset as calculated by the District Valuer and updated by management to make a best estimate of the useful economic life.

- Lease of Tamarind centre
  The Tamarind Centre (a medium secure mental health facility) is owned by Summerhill Supplies Limited and leased to the Trust. The accounting judgement is around the classification of the lease under IAS 17 as either an operating lease or a finance lease.

  Management has reviewed the classification indicators provided within IAS 17 and have assessed that the substance of the transaction is that of an operating lease. The lease term is for 5 years which is a minor part of the economic life of the asset, the lease does not transfer ownership and there is no option to purchase the asset at lower than fair value. The accounting policy for this is described in note 1.11.

  If the substance of the transaction was considered to be a finance lease the Tamarind Centre would be recognised as an asset in these accounts and a creditor would be included to Summerhill Supplies Limited to the value of the asset.

1 **Accounting policies and other information (continued)**

1.17 Critical accounting judgements and key sources of estimation uncertainty (continued)

- Lease of Ardenleigh site
  The Ardenleigh Site (a medium secure mental health facility) is owned by Summerhill Supplies Limited and leased to the Trust. The accounting judgement is around the classification of the lease under IAS 17 as either an operating lease or a finance lease.

  Management has reviewed the classification indicators provided within IAS 17 and have assessed that the substance of the transaction is that of an operating lease. The lease term is for 5 years which is a minor part of the economic life of the asset, the lease does not transfer ownership and there is no option to purchase the asset at lower than fair value. The accounting policy for this is described in note 1.11.

  If the substance of the transaction was considered to be a finance lease the Ardenleigh Site would be recognised as an asset in these accounts and a creditor would be included to Summerhill Supplies Limited to the value of the asset.

- Lease of Juniper centre
  The Juniper Centre (a medium secure mental health facility) is owned by Summerhill Supplies Limited and leased to the Trust. The accounting judgement is around the classification of the lease under IAS 17 as either an operating lease or a finance lease.

  Management has reviewed the classification indicators provided within IAS 17 and have assessed that the substance of the transaction is that of an operating lease. The lease term is for 5 years which is a minor part of the economic life of the asset, the lease does not transfer ownership and there is no option to purchase the asset at lower than fair value. The accounting policy for this is described in note 1.11.

  If the substance of the transaction was considered to be a finance lease the Juniper Centre would be recognised as an asset in these accounts and a creditor would be included to Summerhill Supplies Limited to the value of the asset.

1 **Accounting policies and other information (continued)**

1.17 Critical accounting judgements and key sources of estimation uncertainty (continued)

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the year in which the estimate is revised if the revision affects only that year or in the year of the revision and future years if the revision affects both current and future years.

1.18 Standards applicable from 2017/18 :

No new applicable standards for 2017/18 but amendments to the following:

• IAS 12 Income taxes – amendment relating to the recognition of deferred tax assets for unrealised losses
• IAS 7 Statements of cash flows - amendment to require additional disclosures relating to changes in liabilities arising from financing activities.

This includes all changes in liabilities – both cash and non-cash flow related such as the impact of fluctuations in foreign exchange rates, changes in fair value or gain/ loss of control of subsidiaries. HM Treasury has announced that this amendment will be deferred until 2018/19 although early adoption is permitted in 2017/18.

• IFRS 12 Disclosure of interests in other entities – amendment to clarify the scope of the standard as part of the annual improvements to IFRS 2014-2016.

Standards applicable for future years:

•2018/19
–IFRS 9 financial instruments
–IFRS 15 revenue recognition

•2019/20 and Beyond:
–IFRS 16 leases (no impact has been assessed yet, but it is expected to be significant)
–IFRS 17 Insurance Contracts

1 **Accounting policies and other information (continued)**

1.19 Exceptional items

Exceptional items are those significant items which are separately disclosed by virtue of their size or nature to enable full understanding of the Foundation Trusts financial performance including, but not limited to, material asset impairments and material costs of restructuring.

1.20 Cash and cash equivalents

Cash is defined as cash in hand and any deposits with any financial institution repayable on demand without penalty. Cash equivalents are investments that are short-term and are readily convertible to known amounts of cash with insignificant risk of change in value.

1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had Foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.22 Operating segments

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision-maker. The chief operating decision-maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the board that makes strategic decisions.

1.23 Reachout

Reachout' has been accounted for in line with IFRS 15, with income recognised on a net basis of income and expenditure.

2 **Operating Income (Group)**

	2017/18 £000	2016/17 £000
Income from activities		
Cost and volume contract income	73,242	93,579
Block contract income	137,864	118,716
Other clinical income from mandatory services	4,185	-
Other clinical income	3,255	-
Additional income for delivery of healthcare services	-	-
Total income from activities	218,546	212,295
Other operating income		
Research and development *	1,335	1,689
Education and training	8,405	8,228
Non-patient care services to other bodies	1,388	2,505
Other Income	1,885	5,956
Sustainability and transformation fund income	3,774	3,085
Profit on disposal of property, plant and equipment	-	-
Total other operating income	16,787	21,463
Total operating income	235,333	233,758

2.1 **Income from activities (by Source)**

	2017/18 £000	2016/17 £000
NHS England	71,472	70,482
Clinical commissioning groups	140,029	132,814
NHS Foundation Trusts	2,203	1,779
NHS Trusts	612	612
Local authorities	2,384	2,694
Department of Health and Social Care	-	742
Non NHS: other	1,846	3,172
Total Income from Activities	**218,546**	**212,295**

2.2 **Income from activities arising from mandatory services**

	2017/18 £000	2016/17 £000
Income from activites arising from mandatory services	215,552	209,603
Income from activites arising from non-mandatory services	19,781	24,155
	235,333	233,758

2.3 **Commissioner requested services**

	2017/18 £000	2016/17 £000
Income from activites arising from commissioner requested services	218,546	212,295
Income from activites arising from non-commissioner requested services	-	-
	218,546	212,295

2.4 **Overseas visitors (relating to patients charged directly by the nhs foundation trust)**

	2017/18 £000	2016/17 £000
Income recognised this year	-	-
Cash payments received in year	-	-
Amounts added to provision for impiarment of receviables	-	-
Amounts written off in year	-	-
Total overseas visitor income	-	-

* 16/17 restated due to reclassification between headings in 17/18

3 Segmental analysis

The analysis by business segment is presented in accordance with IFRS 8 Operating segments, on the basis of those segments whose operating results are regularly reviewed by the Board (the Chief Operating Decision Maker as defined by IFRS 8) as follows:

Healthcare services

NHS Healthcare is the core activity of the Trust - the 'mandatory services requirement' as set out in the Trust's Terms of Authorisation issued by NHS Improvement and defined by legislation.

This activity is primarily the provision of NHS healthcare, either to patients and charged to the relevant NHS commissioning body, or where healthcare related services are provided to other organisations by contractual agreement.

Revenue from activities (medical treatment of patients) is analysed by type of activity in note 2 to the accounts.

Other operating income is analysed in note 2 to the accounts and materially consists of revenues from medical education and related support services to other organisations. Revenue is predominately from HM Government and related party transactions are analysed in note 23.1 and 23.2 to the accounts, where individual customers within public sector are considered material.

The healthcare and related support services as described are all provided directly by the Trust, which is a public benefit corporation. These services have been aggregated into a single operating segment because they have similar economic characteristics: the nature of the services they offer are the same (the provision of healthcare), they have similar customers (public and private sector healthcare organisations) and have the same regulators (NHS Improvement and the Department of Health).

Commercial trading - Summerhill Supplies Limited

The company Summerhill Supplies Limited is a wholly owned subsidiary of the Trust and currently leases the Tamarind Centre, the Ardenleigh Site and the Juniper Centre to the Trust. As a trading company, subject to additional legal and regulatory regime (over and above that of the Trust), this activity is considered to be a separate business segment whose individual operating results are reviewed by the Trust Board (the Chief Operating Decision Maker).

A significant proportion of the company's revenue is inter segment trading with the Foundation Trust which is eliminated upon the consolidation of these group accounts. The monthly performance report to the Chief Operating Decision maker reports financial summary information in the format of the table overleaf.

3 Segmental analysis (continued)

Year ended March 31 2018	Healthcare services £000	Commercial trading £000	Inter-group eliminations £000	Total £000
Total segment revenue	235,720	11,196	(11,583)	235,333
Total segment expenditure	(225,478)	(9,808)	12,887	(222,399)
Operating surplus	10,242	1,388	1,304	12,934
Net financing cost	(3,432)	(2,176)	-	(5,608)
PDC dividend payable	(2,390)	-	-	(2,390)
Taxation	-	72	-	72
Retained surplus before non-recurring items	4,420	(716)	1,304	5,008
Non-recurring items	3,406	-	961	4,367
Retained surplus before non-recurring items	7,826	(716)	2,265	9,375
Reportable segment assets	206,159	71,320	-	277,479
Eliminations	-	-	(50,181)	(50,181)
Total Assets	206,159	71,320	(50,181)	227,298
Reportable segment liabilities	(123,058)	(50,856)	-	(173,914)
Eliminations	-	-	51,256	51,256
Total liabilities	(123,058)	(50,856)	51,256	(122,658)
Net assets	83,101	20,464	1,075	104,640

Year ended March 31 2017	Healthcare services £000	Commercial trading £000	Inter-group eliminations £000	Total £000
Total segment revenue	225,985	7,773	(8,005)	225,753
Total segment expenditure	(220,247)	(6,837)	11,636	(215,448)
Operating surplus	5,738	936	3,631	10,305
Net financing cost	(4,223)	(1,431)	-	(5,654)
PDC dividend payable	(2,045)	-	-	(2,045)
Taxation	-	(3)	-	(3)
Retained surplus before non-recurring items	(530)	(498)	3,631	2,603
Non-recurring items	(33,908)	-	-	(33,908)
Retained surplus before non-recurring items	(34,438)	(498)	3,631	(31,305)
Reportable segment assets	205,094	80,866	-	285,960
Eliminations	-	-	(75,240)	(75,240)
Total Assets	205,094	80,866	(75,240)	210,720
Reportable segment liabilities	(128,168)	(52,896)	-	(181,064)
Eliminations	-	-	52,556	52,556
Total liabilities	(128,168)	(52,896)	52,556	(128,508)
Net assets	76,926	27,970	(22,684)	82,212

4 Operating Costs

	2017/18 £000	2016/17 £000
Services from NHS Foundation trusts	4,079	4,772
Services from NHS trusts	784	1,506
Services from CCGs and NHS England	45	324
Services from other NHS bodies	178	507
Employee expenses - executive directors	874	791
Employee expenses - non-executive directors	163	129
Employee expenses - staff	170,135	173,384
Drug costs	5,836	5,587
Supplies and services - clinical (excluding drug costs)	438	492
Supplie and services - general	2,272	2,212
Establishment	2,590	3,055
Transport	1,164	1,122
Premises	19,247	19,408
Increase / (decrease) in bad debt provision	158	119
Termination benefits	302	188
Depreciation on property, plant and equipment	4,526	2,752
Amortisation on intangible assets	588	663
Audit Services	80	77
Other auditors' remuneration	-	5
Clinical negligence	578	413
Loss on disposal of other property, plant and equipment	15	225
Internal audit costs	83	95
Consultancy costs	263	455
Other	8,002	5,172
Total operating costs	222,400	223,453

4.1 Exceptional Items

	2017/18 £000	2016/17 £000
Impairments / (Reversal of impairments) of property, plant and equipment	(4,368)	33,908
Termination Benefits	-	-
Total exceptional items	(4,368)	33,908

Reversal of impairments for the year ended March 31 2018 of £2.3m were due to changes in market price. Impairment charges for the year ended March 31 2017 of £34.0m were as a result of the MEA alternative site valuation method being applied.

4.2 Analysis of loss on disposal

	2017/18 £000	2016/17 £000
Disposal of commissioner requested service assets	-	-
Disposal of non-commissioner requested service assets	15	225
Total loss on disposal	15	225

The Loss in 2017/18 relates to £10k on leasehold improvement works which were written off due to cessation of the lease during the year. A further £5k relates to plant and machinery written off as no longer in use and obsolete. The loss in 2016/17 relates to £200k on buildings which were classified as asset held for sale during the year and also leasehold improvement works which were written off due to cessation of the lease during the year. A further £20k relates to plant and machinery written off as no longer in use and obsolete.

4 **Operating costs (continued)**

4.3 **Auditors' remuneration**

The Board of Governors re-appointed PricewaterhouseCoopers LLP (PwC) as external auditors of the Trust for the three years commencing 2014/15 following a competitive tender exercise. The contract has been extended for a further 2 years. The audit fee for the year ended 31 March 2018 was £49.7k (2017: £48.8k) for the Trust's annual report, £7.3k (2017: £7.2k) for the Trust's quality accounts, £3k (2016/17: nil) for additional payroll controls and new models of care and £8.8k for Summerhill Supplies Limited totalling £65.8k (£63.6k for the year ended 31 March 2017) excluding VAT. This was the fee for an audit in accordance with the Audit Code issued by NHS Improvement in December 2014

4.4 **Other audit remuneration**

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditors :		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	5
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. all assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total audit remuneration	-	5

4.5 **Arrangements containing an operating lease**

	2017/18 £000	2016/17 £000
Minimum lease payments	2,119	2,869

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

The Foundation Trust entered into a number of operating lease arrangements 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 £1,542k (2016/17: £2,168k) which is included within operating costs. The leases for vehicles and equipment range from 1 to 5 years and have an annual charge of £577k (2016/17: £701k) which is included within operating costs.

The Foundation Trusts most significant lease arrangement is for the lease of the Foundation Trust Headquarters. This is a 25 year lease expiring in 2030 and has an annual rental charge of £685k (2016/17: £660k). The lease agreement does not contain provision for contingent rentals and does not impose any restrictions on the Trust. The lease has options for early termination, with penalty, in years 15 and 20 of the lease.

The Tamarind Centre, the Ardenleigh site and the Juniper Centre which are owned by Summerhill Supplies Limited, a wholly owned subsidiary of the Foundation Trust, are being leased to the Foundation Trust. The lease term is for 5 years.

4.6 **Total future minimum lease payments**

	2017/18 £000	2016/17 £000
Not later than one year	1,796	1,206
Later than one year and not later than five years	5,368	4,126
later than five years	7,971	8,979
Total future minimum lease payments	15,135	14,311

5 **Directors remuneration**

	2017/18 £000	2016/17 £000
Short-term benefits :		
Salary	688	610
Taxable benefits	97	86
Performance related bonuses	-	-
employer's pension contributions	89	95
Post-employment benefits :	-	-
Other long-term benefits :	-	-
Termination benedits :	-	-
Share-based payment :	-	-
Total directors remuneration	874	791

The medical director was paid £58k during the year ended March 31 2018 (£57k during year ended March 31 2017), which is not included in the above disclosure, for non-director responsibilities.

Further details of directors' remuneration can be found in the remuneration report.

6 **Employee expenses** (including executive directors but excluding non-executive directors)

	2017/18 £000	2016/17 £000
Salaries and wages	135,148	135,720
Social security costs	13,663	13,322
Employers contribution to NHS pensions	15,783	15,908
Apprenticeship Levy	642	-
Termination benefits (see note 4 and 4.1)	302	188
Agency / contract staff	5,773	9,224
	171,311	174,362
Less: capitalised staff cost		
Total recognised in operating expenses	171,311	174,362

6.1 **Average number of employees (WTE basis)**

	2017/18 Number	2016/17 Number
Medical	221	219
Administration and estates	837	744
Healthcare assistants and oither support staff	644	719
Nursing and health visiting staff	1,186	1,204
Scientific, therapeutic and technical staff	603	598
Other	114	84
Total Average	3,605	3,568

6 **Employee expenses (continued)**

6.2 **Early retirements due to ill health**

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. The information has been supplied by NHS Pensions and these costs are not borne by the Foundation Trust.

	2017/18 £000	2017/18 Number	2016/17 £000	2016/17 Number
No. of early retirements on the grounds of ill health		7		7
Value of early retirements on the grounds of ill health	437		366	

6.3 **Staff exit packages**

Exit package cost band	No. of compulsory redundancies 2017/18	No. of other agreed departures 2017/18	Total no. of exit packages by cost band 2017/18	Total no. of exit packages by cost band 2016/17
< £10,000	2	2	4	3
£10,000 - £25,000	-	2	2	1
£25,001 - £50,000	2	2	4	8
£50,001 - £100,000	1	3	4	3
£100,001 - £150,000	-		-	5
£150,001 - £200,000	-		-	-
Total number of exit packages by type	5	9	14	20
Total resource cost £000			450	1,079

There were no exit packages paid to senior managers during this financial year (2016/17: nil).

7 **Finance Income**

	2017/18 £000	2016/17 £000
Interest on deposits / investments	46	38

8 **Finance costs**

	2017/18 £000	2016/17 £000
Loans from the foundation trust financing facility	1,597	1,680
Finance costs in PFI obligations :		
Main finance costs	2,668	2,729
Contingent finance costs	1,389	1,283
Total finance costs	5,654	5,692

9 Intangible assets

9.1

Group and Trust Intangible assets for year ended March 31 2018	Total	Software licences (purchased)	Licences and trademarks (purchased)	IT (Internally generated and 3rd Party)	Development expenditure (internally generated)
	£000	£000	£000	£000	£000
Gross cost at April 1 2017 - as previously stated	4,078	3,437	253	-	388
Prior period adjustment	-	-	-	-	-
Cost or valuation at April 1 2017	4,078	3,437	253	-	388
Additions - purchased	3,533	2,420	-	552	561
Disposals	-	-	-	-	-
Cost or valuation at March 31 2018	7,611	5,857	253	552	949
Amortisation at April 1 2017 - as previously state	2,796	2,265	253	-	278
Prior period adjustment	-	-	-	-	-
Amortisation at April 1 2017	2,796	2,265	253	-	278
Provided during the year	589	528	-	-	61
Reclassifications	-	-	-	-	-
Disposals	-	-	-	-	-
Amortisation at March 31 2018	3,385	2,793	253	-	339
NBV - Purchased at April 1 2017	1,282	1,172	-	-	110
NBV - Donated at April 1 2017	-	-	-		-
Total NBV at April 1 2017	1,282	1,172	-	-	110
NBV - Purchased at March 31 2018	4,226	3,064	-	552	610
NBV - Donated at March 31 2018	-	-	-		-
Total NBV at March 31 2018	4,226	3,064	-	552	610

9.2

Group and Trust Intangible assets for year ended March 31 2017	Total	Software licences (purchased)	Licences and trademarks (purchased)	IT (Internally generated and 3rd Party)	Development expenditure (internally generated)
	£000	£000	£000	£000	£000
Gross cost at April 1 2016 - as previously stated	4,049	3,408	253	-	388
Prior period adjustment	-	-	-	-	-
Cost or valuation at April 1 2016	4,049	3,408	253	-	388
Additions - purchased	29	29	-	-	-
Disposals	-	-	-	-	-
Cost or valuation at March 31 2017	4,078	3,437	253	-	388
Amortisation at April 1 2016 - as previously state	2,133	1,682	253	-	198
Prior period adjustment	-	-	-	-	-
Amortisation at April 1 2016	2,133	1,682	253	-	198
Provided during the year	663	583	-	-	80
Reclassifications	-	-	-	-	-
Disposals	-	-	-	-	-
Amortisation at March 31 2017	2,796	2,265	253	-	278
NBV - Purchased at April 1 2016	1,916	1,726	-	-	190
NBV - Donated at April 1 2016	-	-	-	-	-
Total NBV at April 1 2016	1,916	1,726	-	-	190
NBV - Purchased at March 31 2017	1,282	1,172	-	-	110
NBV - Donated at March 31 2017	-	-	-	-	-
Total NBV at March 31 2017	1,282	1,172	-	-	110

10 **Property plant and equipment**

10.1

Group property, plant and equipment for year ended March 31 2018	Total	Land	Buildings excl dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at April 1 2017 - as previously stated	192,971	18,496	149,394	-	569	2,680	84	9,893	11,855
Prior period adjustment	-	-	-	-	-	-	-	-	-
Cost or valuation at April 1 2017	192,971	18,496	149,394	-	569	2,680	84	9,893	11,855
Additions - purchased	4,909	-	1,059	-	3,850	-	-	-	-
Additions - donated	-	-	-	-	-	-	-	-	-
Acquisition through business combination	-	-	-	-	-	-	-	-	-
Impairments charged to operating expenses	(390)	(390)	-	-	-	-	-	-	-
Impairments charged to the revaluation reserve	(262)	(262)	-	-	-	-	-	-	-
Reversal of impairments credited to operating expenses	2,939	-	2,939	-	-	-	-	-	-
Reversal of impairments credited to the revaluation reserve	8,948	-	8,948	-	-	-	-	-	-
Reclassifications	-	(1)	3,136	-	(4,162)	167	-	580	280
Revaluation surplus	-	-	-	-	-	-	-	-	-
Transfers to non-current assets classified as held for sale (note 10.7)	-	-	-	-	-	-	-	-	-
Transfers from accumulated depreciation*	-	-	-	-	-	-	-	-	-
Disposals	(27)	-	(10)	-	-	(17)	-	-	-
Cost or valuation at March 31 2018	209,088	17,843	165,466	-	257	2,830	84	10,473	12,135
Accumulated depreciation at April 1 2017 - as previously stated	16,045	-	-	-	-	2,171	82	7,481	6,311
Prior period adjustment	-	-	-	-	-	-	-	-	-
Accumulated depreciation at April 1 2017	16,045	-	-	-	-	2,171	82	7,481	6,311
Provided during the year	4,527	-	1,818	-	-	266	2	791	1,650
Acquisition through business combination	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Reversal of impairments credited to operating expenses	(1,818)	-	(1,818)	-	-	-	-	-	-
Reclassifications	-	-		-	-	-	-	-	-
Revaluation surpluses	-	-	-	-	-	-	-	-	-
Transferred to cost or valuation*	-	-	-	-	-	-	-	-	-
Disposals	(12)	-	-	-	-	(12)	-	-	-
Accumulated depreciation at March 31 2018	18,742	-	-	-	-	2,425	84	8,272	7,961
NBV - Purchased at April 1 2017	175,673	18,066	148,573	-	569	507	2	2,412	5,544
NBV - Donated at April 1 2017	1,253	430	821	-	-	2	-	-	-
Total NBV at April 1 2017	176,926	18,496	149,394	-	569	509	2	2,412	5,544
NBV - Purchased at March 31 2018	190,346	17,843	165,466	-	257	405	-	2,201	4,174
NBV - Donated at March 31 2018	-	-							
Total NBV at March 31 2018	190,346	17,843	165,466	-	257	405	-	2,201	4,174

*These lines represent the elimination of accumulated depreciation against the carrying value of assets which have been revalued in the year in accordance with IAS 16 - Property, Plant and Equipment.

The net book value of assets held under finance lease arrangements is £44,449k at March 31 2018 (£39,085k at March 31 2017). Depreciation of £560k was charged on these assets in the year (£1,014k during the year ended March 31 2017). These assets wholly relate to PFI assets.

The donated assets are restricted to use for the provision of Healthcare education and training.

10 **Property plant and equipment (continued)**

10.2

Trust property, plant and equipment for year ended March 31 2018	Total	Land	Buildings excl dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at April 1 2017 - as previously stated	110,723	10,510	85,621	-	38	1,951	73	9,892	2,638
Prior period adjustment	-	-	-	-	-	-	-	-	-
Cost or valuation at April 1 2017	110,723	10,510	85,621	-	38	1,951	73	9,892	2,638
Additions - purchased	4,073	-	1,059	-	3,014	-	-	-	-
Additions - donated	-	-	-	-	-	-	-	-	-
Acquisition through business combination	-	-	-	-	-	-	-	-	-
Impairments charged to operating expenses	-	-	-	-	-	-	-	-	-
Impairments charged to revaluation reserve	(6,027)	-	(6,027)	-	-	-	-	-	-
Reversal of impairments credited to revaluation reserve	10	10	-	-	-	-	-	-	-
Reversal of impairments credited to operating expenses	2,655	2,655	-	-	-	-	-	-	-
Reclassifications	-	-	1,974	-	(2,795)	-	-	581	240
Revaluation surplus	-	-	-	-	-		-	-	-
Transfers to non-current assets classified as held for sale (note 10.7)	(6,743)	(3,310)	(3,433)	-	-	-	-	-	-
Transfers from accumulated depreciation*	(1,048)	-	(1,048)	-	-	-	-	-	-
Disposals	(27)	-	(10)	-	-	(17)	-	-	-
Cost or valuation at March 31 2018	103,616	9,865	78,136	-	257	1,934	73	10,473	2,878
Accumulated depreciation at April 1 2017 - as previously stated	11,632	-	-	-	-	1,543	73	7,481	2,535
Prior period adjustment	-	-	-	-	-	-	-	-	-
Accumulated depreciation at April 1 2017	11,632	-	-	-	-	1,543	73	7,481	2,535
Provided during the year	2,811	-	1,800	-	-	145	-	791	75
Acquisition through business combination	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Reversal of impairments credited to operating expenses	(752)	-	(752)	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluation surpluses	-	-	-	-	-	-	-	-	-
Transferred to cost or valuation*	(1,048)	-	(1,048)	-	-	-	-	-	-
Disposals	(12)	-	-	-	-	(12)	-	-	-
Accumulated depreciation at March 31 2018	12,631	-	-	-	-	1,676	73	8,272	2,610
NBV - Purchased at April 1 2017	97,838	10,080	84,800	-	38	406	-	2,411	103
NBV - Donated at April 1 2017	1,253	430	821	-	-	2	-	-	-
Total NBV at April 1 2017	99,091	10,510	85,621	-	38	408	-	2,411	103
NBV - Purchased at March 31 2018	90,985	9,865	78,136	-	257	258	-	2,201	268
NBV - Donated at March 31 2018	-								
Total NBV at March 31 2018	90,985	9,865	78,136	-	257	258	-	2,201	268

*These lines represent the elimination of accumulated depreciation against the carrying value of assets which have been revalued in the year in accordance with IAS 16 - Property, Plant and Equipment.

The net book value of assets held under finance lease arrangements is £44,449k at March 31 2018 (£39,085k at March 31 2017). Depreciation of £560k was charged on these assets in the year (£1,014k during the year ended March 31 2017). These assets wholly relate to PFI assets.

The donated assets are restricted to use for the provision of Healthcare education and training.

10 **Property plant and equipment (continued)**

10.3

Group property, plant and equipment for year ended March 31 2017	Total	Land	Buildings excl dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at April 1 2016 - as previously stated	235,583	47,122	169,667	-	139	2,700	84	9,174	6,697
Prior period adjustment	-	-	-	-	-	-	-	-	-
Cost or valuation at April 1 2016	235,583	47,122	169,667	-	139	2,700	84	9,174	6,697
Additions - purchased	5,894	-	1,179	-	4,715	-	-	-	-
Additions - donated	-	-	-	-	-	-	-	-	-
Acquisition through business combination	-	-	-	-	-	-	-	-	-
Impairments charged to operating expenses	(36,474)	(17,239)	(19,235)	-	-	-	-	-	-
Impairments charged to revaluation reserve	(17,127)	(11,387)	(5,740)	-	-	-	-	-	-
Reversal of impairments credited to the revaluation reserve	3,008	-	3,008	-	-	-	-	-	-
Reclassifications	-	-	(1,597)	-	(4,285)	5	-	719	5,158
Revaluation surplus	-	-	-	-	-	-	-	-	-
Transfers to non-current assets classified as held for sale (note 10.7	-	-	-	-	-	-	-	-	-
Transfers from accumulated depreciation*	2,302	-	2,302	-	-	-	-	-	-
Disposals	(215)	-	(190)	-	-	(25)	-	-	-
Cost or valuation at March 31 2017	192,971	18,496	149,394	-	569	2,680	84	9,893	11,855
Accumulated depreciation at April 1 2016 - as previously stated	13,557	-	-	-	-	1,875	80	6,656	4,946
Prior period adjustment	-	-	-	-	-	-	-	-	-
Accumulated depreciation at April 1 2016	13,557	-	-	-	-	1,875	80	6,656	4,946
Provided during the year	2,752	-	264	-	-	296	2	825	1,365
Acquisition through business combination	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	(2,566)	-	(2,566)	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluation surpluses	-	-	-	-	-	-	-	-	-
Transferred to cost or valuation*	2,302	-	2,302	-	-	-	-	-	-
Disposals	-	-	-	-	-	-	-	-	-
Accumulated depreciation at March 31 2017	16,045	-	-	-	-	2,171	82	7,481	6,311
NBV - Purchased at April 1 2016	220,022	45,937	168,854	-	139	819	4	2,518	1,751
NBV - Donated at April 1 2016	2,004	1,185	813	-	-	6	-	-	-
Total NBV at April 1 2016	222,026	47,122	169,667	-	139	825	4	2,518	1,751
NBV - Purchased at March 31 2017	175,673	18,066	148,573	-	569	507	2	2,412	5,544
NBV - Donated at March 31 2017	1,253	430	821	-	-	2	-	-	-
Total NBV at March 31 2017	176,926	18,496	149,394	-	569	509	2	2,412	5,544

*These lines represent the elimination of accumulated depreciation against the carrying value of assets which have been revalued in the year in accordance with IAS 16 - Property, Plant and Equipment.

The net book value of assets held under finance lease arrangements is £39,085k at March 31 2017 (£52,496k at March 31 2016). Depreciation of £1,014k was charged on these assets in the year (£1,294k during the year ended March 31 2016). These assets wholly relate to PFI assets.

The donated assets are restricted to use for the provision of Healthcare education and training.

10 **Property plant and equipment (continued)**

10.4

Trust property, plant and equipment for year ended March 31 2017	Total	Land	Buildings excl dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at April 1 2016 - as previously stated	195,165	40,951	140,213	-	140	1,976	73	9,174	2,638
Prior period adjustment	-	-	-	-	-	-	-	-	-
Cost or valuation at April 1 2016	195,165	40,951	140,213	-	140	1,976	73	9,174	2,638
Additions - purchased	5,357	-	1,175	-	4,182	-	-	-	-
Additions - donated	-	-	-	-	-	-	-	-	-
Acquisition through business combination	-	-	-	-	-	-	-	-	-
Impairments charged to operating expenses	(34,156)	(14,921)	(19,235)	-	-	-	-	-	-
Impairments charged to revaluation reserve	(15,999)	(11,387)	(4,612)	-	-	-	-	-	-
Reversal of impairments credited to the revaluation reserve	3,008	-	3,008	-	-	-	-	-	-
Reclassifications	-	-	3,167	-	(3,885)	-	-	718	-
Revaluation surplus	-	-	-	-	-	-	-	-	-
Transfers to non-current assets classified as held for sale (note 10.7)	-	-	-	-	-	-	-	-	-
Transfers from accumulated depreciation*	(1,779)	-	(1,779)	-	-	-	-	-	-
Disposals	(40,873)	(4,133)	(36,316)	-	(399)	(25)	-	-	-
Cost or valuation at March 31 2017	110,723	10,510	85,621	-	38	1,951	73	9,892	2,638
Accumulated depreciation at April 1 2016 - as previously stated	10,361	-	-	-	-	1,392	73	6,656	2,240
Prior period adjustment	-	-	-	-	-	-	-	-	-
Accumulated depreciation at April 1 2016	10,361	-	-	-	-	1,392	73	6,656	2,240
Provided during the year	4,493	-	3,222	-	-	151	-	825	295
Acquisition through business combination	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	(1,443)	-	(1,443)	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluation surpluses	-	-	-	-	-	-	-	-	-
Transferred to cost or valuation*	(1,779)	-	(1,779)	-	-	-	-	-	-
Disposals	-	-	-	-	-	-	-	-	-
Accumulated depreciation at March 31 2017	11,632	-	-	-	-	1,543	73	7,481	2,535
NBV - Purchased at April 1 2016	182,800	39,766	139,400	-	140	578	-	2,518	398
NBV - Donated at April 1 2016	2,004	1,185	813	-	-	6	-	-	-
Total NBV at April 1 2016	184,804	40,951	140,213	-	140	584	-	2,518	398
NBV - Purchased at March 31 2017	97,838	10,080	84,800	-	38	406	-	2,411	103
NBV - Donated at March 31 2017	1,253	430	821	-	-	2	-	-	-
Total NBV at March 31 2017	99,091	10,510	85,621	-	38	408	-	2,411	103

*These lines represent the elimination of accumulated depreciation against the carrying value of assets which have been revalued in the year in accordance with IAS 16 - Property, Plant and Equipment.

The net book value of assets held under finance lease arrangements is £39,085k at March 31 2017 (£52,496k at March 31 2016). Depreciation of £1,014k was charged on these assets in the year (£1,294k during the year ended March 31 2016). These assets wholly relate to PFI assets.

The donated assets are restricted to use for the provision of Healthcare education and training.

10 **Property plant and equipment (continued)**

10.5 **Economic life of property, plant and equipment**	Min Life Years	Max Life Years
Land	-	-
Buildings excluding dwellings	10	77
Assets under construction	-	-
Plant and machinery	1	5
Transport equipment	1	1
Information technology	1	4
Furniture and fittings	1	5
Intangible Assets	1	5

10.6 **Valuations**

Valuations are carried out by professionally qualified, independent valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Fair values were determined based on estimates. The impairment gains and loss recognised in the accounts arose due to movement in market prices.

10.7 **Non-current assets classified as held for sale**	Group		Trust	
	March 31 2018 £000	March 31 2017 £000	March 31 2018 £000	March 31 2017 £000
Property, plant and equipment	-	-	6,743	-

Group assets classified as held for sale during the year ended March 31 2018 were £nil (2016/17: nil). Trust assets classified as held for sale during the year ended March 31 2018 were £6,743k relating to the proposed sale of Reaside Clinic to the group subsidiary company Summerhill Supplies Ltd (2016/17: nil).

11 **Inventories**	Group		Trust	
	March 31 2018 £000	March 31 2017 £000	March 31 2018 £000	March 31 2017 £000
Drugs	333	288	183	195
Consumables	25	59	25	59
Total Inventories	358	347	208	254

11.1 **Inventories recognised in expenses**	March 31 2018 £000	March 31 2017 £000
Inventories recognised in expenses	4,199	3,863
Write-down of inventories recognised as an expense	20	84
Reversals of any write down of inventories	-	-
Total inventories recognised in expenses	4,219	3,947

12 **Subsidiary investment**	Group		Trust	
	March 31 2018 £000	March 31 2017 £000	March 31 2018 £000	March 31 2017 £000
Shares in group undertakings	-	-	23,036	23,036
Total Subsidiary investment	-	-	23,036	23,036

The Trust's principal subsidiary undertaking as included in the consolidation as at the reporting date is set out below. The reporting date of the accounts for the subsidiary is the same as for these group accounts - March 31 2018.

Summerhill Supplies Limited

The company is registered in the UK, company number 08015667. The company commenced trading on December 1 2012 and is a wholly owned subsidiary of Birmingham and Solihull Mental Health NHS Foundation Trust with share capital of £23,036,225 (2016/17: £23,036,223). The current purpose of the company is to own, and provide a managed lease service for Tamarind Centre, Ardenleigh Site and Juniper Centre to the Trust, and also provide a outpatient dispensing service to the Trust which commenced in September 2013.

13 **Group trade and other receivables**

	Total March 31 2018 £000	Financial assets March 31 2018 £000	Non-financial assets March 31 2018 £000	Total March 31 2017 £000	Financial assets March 31 2017 £000	Non-financial assets March 31 2017 £000
Current						
NHS receivables	10,552	10,552	-	4,992	4,992	-
Other receivables with related parties	-	-	-	-	-	-
Provision for impaired receivables	(257)	(257)	-	(227)	(227)	-
Prepayments	2,106	-	2,106	2,652	-	2,652
PDC receivable	213	213	-	1,578	1,578	
Other receivables	1,946	1,946	-	10,669	10,669	
Total current trade and other receivables	14,560	12,454	2,106	19,664	17,012	2,652
Non-current						
Prepayments - Lifecycle replacement	1,512	-	1,512	1,315	-	1,315
Total non-current trade and other receivables	1,512	-	1,512	1,315	-	1,315

13.1 **Trust trade and other receivables**

	Total March 31 2018 £000	Financial assets March 31 2018 £000	Non-financial assets March 31 2018 £000	Total March 31 2017 £000	Financial assets March 31 2017 £000	Non-financial assets March 31 2017 £000
Current						
NHS receivables	10,552	10,552		4,992	4,992	-
Other receivables with related parties	-	-	-	-	-	-
Provision for impaired receivables	(257)	(257)	-	(227)	(227)	-
Prepayments	2,106	-	2,106	2,652	-	2,652
PDC receivable	213	213	-	1,578	1,578	-
Other receivables	1,624	1,624		10,660	10,660	-
Loan assets*	1,821	1,821	-	1,789	1,789	-
Total current trade and other receivables	16,059	13,953	2,106	21,444	18,792	2,652
Non-current						
Prepayments - Lifecycle replacement	1,512	-	1,512	1,315	-	1,315
Loan assets*	47,736	47,736	-	49,557	49,557	-
Total non-current trade and other receivables	49,248	47,736	1,512	50,872	49,557	1,315

*Loan assets are comprised solely of loans made to the 100% owned subsidiary Summerhill Supplies Limited. The term of these loans is 25 years.

13 **Trade and other receivables (continued)**

13.2

Provision for impairment of receivables - group and trust	2017/18 £000	2016/17 £000
At April 1	227	367
Increase in provision	158	119
Amounts utilised	(128)	(259)
Unused amounts reversed	-	-
At March 31	257	227

13.3

Analysis of impaired receivables - group and trust	March 31 2018 £000	March 31 2017 £000
Ageing of impaired receivables:		
Up to three months	42	25
In three to six months	28	28
Over six months	187	174
Total impaired receviables	257	227

13.4

Ageing of non-impaired receivables past their due date - group and trust	March 31 2018 £000	March 31 2017 £000
Up to three months	3,945	12,092
90-180 days (was "in three to six months")	490	476
Over 180 days (was "over six months")	834	399
Total non-impaired receviables past their due date	5,269	12,967

The Value of Receivables not past their due date is £2,388k in this financial year (£2,362k in 2016/17)

14 **Group trade and other payables**

	Total March 31 2018 £000	Financial liabilities March 31 2018 £000	Non-financial liabilities March 31 2018 £000	Total March 31 2017 £000	Financial liabilities March 31 2017 £000	Non-financial liabilities March 31 2017 £000
Current						
NHS payables	2,997	2,997	-	2,095	2,095	-
Amounts due to other related parties	-	-	-	-	-	-
Trade payables - capital	786	786	-	875	875	-
Social security and taxes payable	3,637	-	3,637	3,242	-	3,242
Other payables	7,552	7,552	-	8,005	8,005	-
Accruals	7,908	7,908	-	7,138	7,138	-
Total current trade and other payables	22,880	19,243	3,637	21,355	18,113	3,242

14.1 **Trust trade and other payables**

	Total March 31 2018 £000	Financial liabilities March 31 2018 £000	Non-financial liabilities March 31 2018 £000	Total March 31 2017 £000	Financial liabilities March 31 2017 £000	Non-financial liabilities March 31 2017 £000
Current						
NHS payables	2,997	2,997	-	2,095	2,095	-
Amounts due to other related parties	-	-	-	-	-	-
Trade payables - capital	759	759	-	829	829	-
Social security and taxes payable	3,637	-	3,637	3,242	-	3,242
Other payables	6,569	6,569		6,866	6,866	-
Accruals	8,566	8,566		7,982	7,982	-
Total current trade and other payables	22,528	18,891	3,637	21,014	17,772	3,242

Other payables above includes £1,328k at March 31 2018 in respect of outstanding employer Pension contributions (£1,277k at March 2017).

15 **Other Liabilities - Group**

	March 31 2018 £000	March 31 2017 £000
Current		
Deferred Income	4,288	3,974
Total current other Liabilities	4,288	3,974

15.1 **Other Liabilities - Trust**

	March 31 2018 £000	March 31 2017 £000
Current		
Deferred Income	4,288	3,974
Deferred gain on disposal	656	656
Total current other Liabilities	4,944	4,630
Non-current		
Deferred gain on disposal	1,803	2,459
Total non-current other Liabilities	1,803	2,459

16 **Borrowings - Group and Trust**

	March 31 2018 £000	March 31 2017 £000
Current		
Loans from foundation trust financing facility	2,183	2,183
Obligations under private finace initiative contracts	1,425	1,289
Total current borrowings	3,608	3,472
Non-current		
Loans from foundation trust financing facility	36,054	38,237
Obligations under private finance initiaive contracts	54,006	55,429
Total Non-current borrowings	90,060	93,666

16.1 **Borrowings - Trust**

	March 31 2018 £000	March 31 2017 £000
Current		
Loans from foundation trust financing facility	2,183	2,183
Obligations under private finace initiative contracts	1,425	1,289
Loans from Subsidiary Company	750	-
Total current borrowings	4,358	3,472
Non-current		
Loans from foundation trust financing facility	36,054	38,237
Obligations under private finance initiaive contracts	54,006	55,429
Total Non-current borrowings	90,060	93,666

17 **Prudential borrowings limit**

Prudential Borrowing Limit disclosures are no longer required, the Prudential Borrowing Code having been repealed by the Health and Social Care Act 2012

18 **PFI obligations (on SOFP) - group and trust**

	March 31 2018 £000	March 31 2017 £000
Gross PFI liabilities of which liabilities are due:		
- Not later than one year;	4,032	3,956
- Later than one year and not later than five years;	16,155	16,131
- Later than five years.	73,946	78,001
Finance charges allocated to future periods	(38,702)	(41,369)
Net PFI Liabiliites	55,431	56,719
- Not later than one year;	1,425	1,290
- Later than one year and not later than five years;	6,426	6,116
- Later than five years.	47,580	49,313
Total PFI obligations	55,431	56,719

18.1 **PFI obligations - Group and trust**

The Trust is committed to make the following payments for on SoFP PFIs obligations during the next year in which the commitment expires:

	March 31 2018 Total £000	March 31 2018 PFI 1 £000	March 31 2018 PFI 2 £000	March 31 2017 Total £000
16th to 20th years (inclusive)	3,600	3,600	-	3,455
26th to 30th years (inclusive)	7,847	-	7,847	7,132

18.2 **PFI total commitments (on SOFP) - group and trust**

	March 31 2018 £000	March 31 2017 £000
- Not later than one year;	11,087	10,587
- Later than one year and not later than five years;	47,189	45,061
- Later than five years.	331,822	336,455
Total commitments in respect of the PFI	390,098	392,103
- Not later than one year;	10,540	10,064
- Later than one year and not later than five years;	39,591	37,798
- Later than five years.	162,037	160,402
Total present value of commitments	212,168	208,264

18.3 **PFI service commitments (on SOFP) - group and trust**

	March 31 2018 £000	March 31 2017 £000
Charge in respect of the service element of the PFI for the period	3,905	3,825
Commitments in respect of the service element of the PFI:		
- Not later than one year;	3,874	3,688
- Later than one year and not later than five years;	14,807	14,048
- Later than five years.	66,502	65,598
	85,183	83,334

18.4 **PFI contract details**

The Foundation Trust has entered into two PFI contracts:

PFI 1 - Northern PFI Scheme

This is a 35 year contract with Healthcare Support (Erdington) Limited which commenced in April 2002 and is for the provision of six buildings including "hard" facility management services. The service provision is implicitly for the patients, staff and visitors of the Trust. This contract has been treated as being on-statement of financial position by the Trust following a review of the contracts based on Treasury Task force Technical Note 1 "How to account for PFI transactions" which interprets IAS16 "Property, Plant and Equipment" and IFRIC12" Service Concession Arrangements". The increase in annual Unitary Charge is linked to annual movement is RPIx.

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

The Contract also includes the provision of "soft" facility management services. These services are also linked to the annual movement in RPIx but are subject to a market testing exercise which takes place every 5 years. This commenced in January 2014.

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

PFI 2 - Birmingham New Hospital Projects

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

19 **Provisions for Liabilities and charges - group and trust**

	Total	Legal claims	Property	Restructuring	Injury allowance	Other
	£000	£000	£000	£000	£000	£000
At April 1 2017	2,927	192	983	290	1,159	303
Arising during the year	660	110	171	-	9	370
Utilised during the year	(301)	(57)	(25)	(149)	(70)	-
Reversed unused	(234)	-	(50)	(11)	-	(173)
At March 31 2018	3,052	245	1,079	130	1,098	500
Expected timing of cash flows:						
- Not later than one year;	1,262	245	317	130	70	500
- Later than one year and not later than five years;	686	-	406	-	280	-
- Later than five years.	1,104	-	356	-	748	-
Total provisions for liabilities and charges	3,052	245	1,079	130	1,098	500

The legal claims provision relates to personal legal claims that have been lodged against the Foundation Trust with the NHS Resolution (Formerly NHSLA) but not yet agreed. The exact timing or amount of any payment will only be known once the case is heard, although it is expected that all cases will be resolved during the year ended March 31 2019.

The Trust has £73k of contingent liabilities in respect of legal claims notified by NHS Resolution for potential employer and public liability claims over and above those detailed above at March 31 2018 (£89k at March 31 2017).

The property provision consists of amounts payable on dilapidation costs. Dilapidation provisions are based on managements best estimate of settling dilapidation costs contained within lease contracts but the exact liability will only be known once settlement has been agreed with the lessor. The timing of the cash flows is based on the length of the lease.

The restructuring provision relates to the cost of restructuring a service where an obligation exists at the year end; the most significant cost being redundancy and termination payments. Provisions are only recognised after a clear decision has been made to remove a post and the decision has been communicated to those affected. It is likely that these amounts will be settled during the year ended March 31 2019.

The injury allowance provision relates to permanent injury and early retirement provisions. The liability of the Foundation Trust is dependant based on life expectancy.

The other provision consists of £160k for Increment Provision, £25k Yewcroft excess provision, £10k Information Governance Breach Provision, £105k RAIDPlus Infringement Case and £200k HMRC Compliance Provision .

19.1 **Clinical Negligence liabilities - group and trust**

	March 31 2018	March 31 2017
	£000	£000
Amount included in provisions of the NHS Resolutions (formerly NHSLA) in respect of clinical negligence liabilities of Birmingham and Solihull Mental Health NHS Foundation Trust	1,877	3,943

20 **Contractual capital commitments - group and trust**

The Group was contractually committed to £262k at 31 March 2018 (£642k at 31 March 2017) of capital expenditure for the purchase of property, plant and equipment.

21 **Third party assets**

The trust held £1,078k cash and cash equivalents at March 31 2018 (£859k March 31 2017) which relates to monies held by the Foundation Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

22 **Cash and cash equivalents**

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
At April 1	11,151	22,202	9,115	20,719
Net change in year	6,264	(11,051)	7,766	(11,604)
At March 31	17,415	11,151	16,881	9,115
Broken down into:				
Cash in hand (petty cash)	54	39	54	39
Cash at commercial banks	534	2,036	-	-
Cash at GBS	16,827	9,076	16,827	9,076
Cash and cash equivalents as in SOFP	17,415	11,151	16,881	9,115
Bank overdraft				
Cash and cash equivalents as in SOCF	17,415	11,151	16,881	9,115

23 **Ultimate parent company**

The Foundation Trust is a public benefit corporation established under the NHS Act 2006. NHS Improvement, the NHS Foundation Trust Regulator, has the power to control the Trust within the meaning of IAS 27 'Consolidated and Separate Financial Statements' and therefore can be considered as the Trust's parent. NHS Improvement 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. NHS Improvement is accountable to the Secretary of State for Health. The Foundation Trust's ultimate parent is therefore HM Government.

23.1 **Related party transactions**

The Foundation Trust has taken advantage of the exemption provided by IAS 24 'Related Party Disclosures', where the parent's own accounts are presented together with the consolidated accounts and any transactions or balances between group entities have been eliminated on consolidation.

During the year the Foundation Trust did not enter into any material transactions with Board members, governors, key staff members or parties related to them. The Trust did have material transactions with entities within the Whole of Government, details of which are listed below. We have disclosed any values over £1.5m as we consider this to be significant (prior period comparatives remain)

	Income > £1.5m	
	2017/18	2016/17
	£000	£000
University Hospital Birmingham NHS Foundation Trust	2,017	1,270
NHS Birmingham Cross City CCG	118,810	118,362
NHS England	73,716	71,905
NHS Solihull CCG	16,560	16,292
Health Education England	8,132	8,312
Heart of England NHS Foundation Trust	1,674	1,599
Solihull Metropolitan Borough Council	2,601	2,826

	Expenditure > £1.5m	
	2017/18	2016/17
	£000	£000
Birmingham Community Healthcare NHS Trust	3,275	3,508

23.2 **Related party balances**

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

	Receivables > £0.5m	
	March 31 2018	March 31 2017
	£000	£000
NHS England	3,995	2,327
HMRC (VAT)	1,034	1,068
Heart of England NHS Foundation Trust	542	511
Department of Health (PDC)	213	1,578
University Hospital Birmingham NHS Foundation Trust	719	243
NHS Birmingham Cross City CCG	1,280	205
Birmingham Women's and Children's Hospital NHS Foundation Trust	529	177

	Payables > £0.5m	
	March 31 2018	March 31 2017
	£000	£000
Birmingham City Council	31	713
NHS England	973	757
HMRC	3,637	3,242

The Foundation Trust is the Corporate Trustee of Birmingham and Solihull Mental Health NHS Foundation Trust Charity Caring Minds (Charity number 1098659) and provides administration services for the Charity. At March 31 2018 the Trust was owed £91k (£36k at March 31 2017) from the Charity for expenses incurred by the Trust related to the Charity.

The Foundation Trust is parent of the wholly owned subsidiary Summerhill Supplies Limited. At March 31 2018 the Trust was owed £49,557k from the company (£51,346K at 31 March 2017) . Income from Summerhill Supplies Limited during the year amounted to £11,196k (£7,773k at 31 March 2017) and the expenditure incurred was £11,912k (£8,271k at 31 March 2017).

All related party balances are not secured, are on standard Foundation Trust terms and conditions and will be settled in cash

23.3 **Declaration of Interest - Board**

Name of Person	Name of Organisation	Interest
Sue Davis	West Midlands Constitutional Connection	Director of lobbying organisation
	NHS Providers Association	Vice Chair
	West Midlands Police	Independent Chair of the Joint Audit Committee
	*Birmingham City Council	*Husband Councillor - Billesley Ward
	*BSMHFT	*Husband Lay Member of BSMHFT Nephew and Niece (by marriage) employees
John Short	*Ramsey Systems	*Daughter Employee
Brendan Hayes	NIL	NIL
Dr Hilary Grant	NIL	NIL
Sue Hartley	NIL	NIL
Dave Tomlinson	DEAT Consulting Limited which has previously provided services to the NHS	95% Shareholder and Director
	Summerhill Supplies Limited	Director
Charlotte Bailey	NIL	NIL
Barry Henley	Birmingham City Council	Councillor
	Service Birmingham	Director
	King David School	Governor (From May 2014)
Joy Warmington	BRAP	Chief Executive Officer
	Birmingham and Solihull social economy consortium	Member
	Migrant Voice (Appointed 9th Feb 2017)	Trustee
Dr Nerys Williams	Solihull MBC	Member of Independent Remuneration Panel
	University of Warwick	Honorary Associate Professor
	General Medical Council	Examiner and Question writer PLAB
	ACME at UCL for GMC	Pilot OSCE writer and Assessor
	Editorial Board of Society of Occupational Medicine Journal published by Oxford University Press	Editorial assistant and editorial board member
	British Horse Society	Member of Audit Committee
	Her Majestys Courts and Tribunals Service	Judicial Office holder to the First Tier Social Entitlement Chamber
Waheed Saleem	WS Associates Midlands Limited	Owner / Director
	Walsall Alliance Limited	Managing Director
	Caring Minds Charity	Ambassador
	Sahaara Care Limited	Director and Registered Manager - Ended 01/10/16
	Amirah Foundation	Trustee (Resigned Feb 2017)
	Strategic Police and Crime Board - West Midlands Police and Crime Commissioner	Non Executive Director
	Waldoc Limited	Director
Gianjeet Hunjan	University of Birmingham	College Finance Manager
	ACCEA	Chair – West Midlands
	Oldbury Academy	Governor
	Ferndale Primary School	Governor
Russell Beale (Appointed 01/01/17)	CloudTomo	Director, shareholder - Security company pre-commercial
	BeCrypt	Founder and Minority Shareholder - Computer Security Company
	Azureindigo	Director, 50% shareholder - Health and behaviour change company working in (physical and mental health) domains
	University of Birmingham	Professor
	*BCH	*Spouse is a consultant in Paediatric A&E and a co-director of azureindigo
	Interacting with Computers	Journal Editor
	Hodnet Primary School	Governor
	Worcester Schools Sailing Association	Honorary Race Coach
	Walsall Healthcare NHS Trust	Non-Executive Director
	University of Southampton	External Examiner
	Various UK and International Universities	PHD examiner
	Various International Government or Reasearch Organisations	Evaluator
	EPSRC	Member

24 **Financial risk management**

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Foundation Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Foundation Trust's standing financial instructions and policies agreed by the Board of Directors. The Foundation Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

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

Interest rate risk

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

Credit risk

Because the majority of the Foundation Trust's income comes from contracts with other public sector bodies, the Foundation Trust has low exposure to credit risk. The maximum exposures as at March 31 2018 are in receivables from customers, as disclosed in the Trade and other receivables note. The risk associated with cash and deposits with financial institutions (National Loan Funds) is considered to be low as trading cash is held with the Government Banking Service and deposits are only placed on a short term basis with highly rated UK banks.

Liquidity risk

The Foundation Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Foundation Trust funds its capital expenditure from funds from robust management of its cash-flows. The Foundation Trust is not, therefore, exposed to significant liquidity risks.

25	Group financial assets by category	March 31 2018 Loans and receivables £000	March 31 2017 Loans and receivables £000
	Assets as per SOFP		
	Trade and other receivables exlcuding non financial assets	12,454	17,012
	Cash and cash equivalents (at bank and in hand)	17,415	11,151
	Total group financial assets at March 31	29,869	28,163

25.1	Trust financial assets by category	March 31 2018 Loans and receivables £000	March 31 2017 Loans and receivables £000
	Assets as per SOFP		
	Trade and other receivables exlcuding non financial assets	13,953	18,792
	Cash and cash equivalents (at bank and in hand)	16,881	9,115
	Total trust financial assets at March 31	30,834	27,907

26	Group financial liabilities by catergory	March 31 2018 Other financial liabilities £000	March 31 2017 Other financial liabilities £000
	Liabilities as per SOFP		
	Borrowings excluding finance lease and PFI liabilities	38,237	40,420
	Obligations under private finance initiative contracts	55,431	56,719
	Trade and other payables excluding non financial liability	19,243	18,113
	Total group financial liabilities at March 31	112,911	115,252

26.1	Trust financial liabilities by catergory	March 31 2018 Other financial liabilities £000	March 31 2017 Other financial liabilities £000
	Liabilities as per SOFP		
	Borrowings excluding finance lease and PFI liabilities	38,987	40,420
	Obligations under private finance initiative contracts	55,431	56,718
	Trade and other payables excluding non financial liability	18,891	17,772
	Total trust financial liabilities at March 31	113,309	114,910

27 **Losses and special payments**

NHS Foundation Trusts are required to report to the Department of Health any losses or special payments, as the Department of Health still retains responsibility for reporting these to Parliament.

There were 67 cases of losses and special payments totalling £133k during the year to March 31 2018 (128 cases totalling £228k during the year to March 31 2017). These amounts are reported on an accruals basis but excluding provisions for future losses.

Losses and special payments (approved cases only)	2017/18 Total No. of cases Number	2017/18 Total value of cases £000	2016/17 Total no. of cases Number	2016/17 Total value of cases £000
Losses:				
Losses of cash due to :				
Theft, fraud etc	6	1	5	1
Fruitless payments and constructive losses	-	-	1	20
Bad debts and claims abandoned in relation to :				
Other	22	28	98	74
Damage to buildings, property etc. (including stores losses) due to:				
Theft, fraud etc	-	-	2	11
Store losses	1	18	1	83
Other	-	-	-	-
Total Losses	29	47	107	189
Special payments :				
Compensation under legal obligation	16	77	5	36
Ex gratia payments; in respect of; loss of personal effects	22	9	16	3
Total special payments	38	86	21	39
Total losses and special payments	67	133	128	228

28 **Pensions**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

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Corporation Tax Expense	2017/18 £000	2016/17 £000
UK corporation tax expense	-	-
Adjustment in respect of prior years	-	-
Current tax expense	-	-
Origination and reversal of temporary differences	(72)	3
Deferred tax expense	(72)	3
Total income tax expense in statement of comprehensive income	(72)	3
Reconciliation of effective tax charge		
Effective tax charge percentage	-	-
Tax if effective tax rate charged on surpluses before tax	-	-
Effect of :		
Surpluses not subject to tax	-	-
Non-deductible expenses	-	-
Adjustments in respect of prior years	-	-
Share of results of joint ventures and associates	-	-
Change in tax rate	-	-
Other	-	-
Total income tax charge for the year	-	-

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Deferred tax asset	2017/18 £000	2016/17 £000
Deferred tax asset to be recovered after > 12 months	111	38
Deferred tax liability to be recovered after > 12 months	-	-
Total deferred tax asset	111	38

Annual accounts
Documents prepared by the FT to show its financial position. Detailed requirements for the annual accounts are set out in the Department of Health Group Accounting Manual , published by NHSI. The *Annual Reporting Manual* was previously called the *Foundation Trust Financial Reporting Manual* .

Annual report
A document produced by the FT that summarises the FT's performance during the year, including the annual accounts.

Asset
Something the FT owns – for example a building, some cash, or an amount of money owed to it.

Audit Code
Audit Code for Foundation Trusts
A document issued by NHS Improvement, which sets out how FT audits must be conducted.

Audit opinion
The auditors' opinion of whether the FT's accounts show a true and fair view of its financial affairs. If the auditors are satisfied with the accounts, they will issue an unqualified audit opinion.

Available for sale
Assets are classed as available for sale if they are held neither for trading nor to maturity. An example of this would be an investment without a maturity date such as an ordinary share.

Statement of Financial Position
A year-end statement prepared by all public and private sector organisations, which shows the net assets controlled by the organisation and how these have been funded. The balance sheet is known as the Statement of Financial Position under IFRS.

Breakeven
An FT has achieved breakeven if its income is greater than or equal to its expenditure.

Cash and cash equivalents
Cash includes cash in hand and cash at the bank. Cash equivalents are any other deposits that can be converted to cash straight away.

Corporation tax
A tax payable on a company's profits. FTs may have to pay corporation tax in the future.

Current asset or current liability
An asset or liability the FT expects to hold for less than one year.

Depreciation
An accounting charge to represent the use, or wearing out, of assets. As a result the cost of an asset is spread over its useful life.

Earnings before interest, tax, depreciation and amortisation (EBITDA)
A measure of an FT's financial performance excluding interest, tax, depreciation and amortisation. EBITDA is used to calculate some of NHS Improvements risk ratings.

External auditor
The independent professional auditor who reviews the accounts and issues an opinion on whether the accounts present a true and fair view.

External financing limit
A measure of the movement in cash an FT is allowed in the year, which is set by the government.

Finance lease
An arrangement whereby the party leasing the asset has most or all of the use of an asset, and the lease payments are akin to repayments on a loan.

Financial statements
Another term for the annual accounts.

Department of Health Group Accounting Manual (GAM)
The key document, published annually by NHS Improvement, setting out the framework for the FT'S accounts. Now called the Group Accounting Manual (GAM).

Going concern
The accounts are prepared on a going concern basis, in other words with the expectation that the FT will continue to operate for at least the next 12 months.

Impairment
A decrease in the value of an asset.

Intangible asset
An asset that is without substance, for example computer software.

International Financial Reporting Standards (IFRS)
The new accounting standards that the NHS has adopted from April 2009.
International Standards on Auditing (United Kingdom and Ireland) (ISAs (UK&I))
The professional standards external auditors must comply with when carrying out audits.

Inventories
Stock, such as clinical supplies.

Liability
Something the FT owes, for example an overdraft, a loan, or a bill it has not yet paid.

Liquidity ratio
Liquidity is a measure of how easily an asset can be converted into cash. Bank deposits are very liquid, debtors less so. The liquidity ratio is a measure of an entity's ability to meet its obligations, in other words how well it can pay its bills from what it owns.

Non-current asset or liability
An asset or liability the FT expects to hold for more than one year.

Non-executive director
Non-executive directors are members of the FT's board of directors but do not have any involvement in day-to-day management of the FT. They provide the board with independent challenge and scrutiny.

Operating lease
An arrangement whereby the party leasing the asset is paying for the provision of a service (the use of the asset) rather than exclusive use of the asset.

Payables
Amounts the FT owes.

Clinical Commissioning Groups (CCG's)
The body responsible for commissioning all types of healthcare services across a specific locality.

Primary statements
The four main statements that make up the accounts: the Statement of Comprehensive Income; Statement of Financial Position; Statement of Changes in Taxpayers' Equity; and Statement of Cash Flows.

Private Finance Initiative (PFI)
A way of funding major capital investments, without immediate recourse to the public purse. Private consortia, usually involving large construction firms, are contracted to design, build, and in some cases manage new projects. Contracts typically last for 30 years, during which time the building is leased by the FT.

Provision
A liability of uncertain timing or amount.

Prudential Borrowing Code
NHS Improvements mechanism to limit the total amount an FT is allowed to borrow. The Code sets out how to determine an FT's prudential borrowing limit.

Prudential borrowing limit
The amount of money an FT is allowed to borrow, as agreed with NHS Improvement

Public dividend capital
Taxpayers' equity, or the taxpayers' stake in the FT, arising from the government's original investments in NHS trusts when they were first created.

Receivables
Amounts owed to the FT.

Remuneration report
The part of the annual report that discloses senior officers' salary and pension information.

Reserves
Reserves represent the increase in overall value of the organisation since it was first created.

Statement of Cash Flows
The name for the cash flow statement under IFRS. It shows cash flows in and out of the FT during the period.

Statement of Changes in Taxpayers' Equity
One of the primary statements which shows the changes in reserves and public dividend capital in the period.

Statement of Comprehensive Income
The new name for the income and expenditure account, and the public sector equivalent of the profit and loss account. It shows what income has been earned in the year, what expenditure has been incurred and hence the surplus or deficit for the year.

Statement on Internal Control
A statement about the controls the FT has in place to manage risk.

Those charged with governance
Auditors' terminology for those people who are responsible for the governance of the FT, usually the audit committee.

True and fair
It is the aim of the accounts to show a true and fair view of the FT's financial position, that is they should faithfully represent what has happened in practice.

UK GAAP (Generally Accepted Accounting Practice)

The standard basis of accounting in the UK before international standards were adopted.

Unrealised gains and losses
Gains and losses may be realised or unrealised. Unrealised gains and losses are gains or losses that the FT has recognised in its accounts but which are potential as they have not been realised. An example of a gain that is recognised but unrealised is where the value of assets has increased. This gain is realised when the assets are sold or otherwise used

Noted	Meaning
"k"	'000
" £ m"	'000,000
" '000 "	'000

Birmingham and Solihull Mental Health
NHS Foundation Trust
Unit 1, 50 Summer Hill Road
Birmingham
B1 3RB

Main switchboard: 0121 301 0000
Website: www.bsmhft.nhs.uk