NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Annual report and accounts 2018/19

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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 2018 to 31 March 2019.

The year saw some exciting and innovative developments across the Trust. These ranged from the launch of new services such as the Complex Treatment Service for veterans and a new regional forensic community service for forensic children and adolescents, to digital innovations and further development of new care models to improve patient care.

For many years we have been at the forefront of innovation in mental health services, for example in the development of liaison psychiatry and home treatment and 2018/19 was no exception. We completed the second phase of our 'Digital Ward' programme, which replaces cumbersome written notes with an app that now allows physical as well as therapeutic observations to be recorded in real time on a hand held device, linked directly to our electronic patient record. This has received national recognition as part of the national Global Digital Exemplar programme, with NHS England recently making a film featuring our ward staff talking about the difference this has made to their experience and to the care they are able to provide. Another unique and innovative piece of work during the year was the piloting of 'predictive analytics' within community teams to test an algorithm to see if it accurately predicts service users who are at high risk of experiencing a mental health crisis. This work continues into 2019/20.

Partnership working is also something that we have championed over a number of years and our Reach Out and MERIT partnerships, in secure and acute/urgent care respectively, have continued to make a difference in providing care closer to home, with recovery at the heart of their work. We have also continued to play an active role in the development of the Birmingham and Solihull Sustainability and Transformation Partnership strategy. This year we have forged new and innovative partnerships in other areas. One of these involves a different model of primary mental health care, being piloted in East Birmingham. This sees a multi-disciplinary team comprising NHS mental health and community professionals, GPs, local authority and the voluntary sector coming together to ensure a holistic and person-centred approach to tackling the issues affecting an individual's mental health, whether it be health, social care or other factors such as housing or isolation. We've also brought together leaders from the NHS, local authorities, universities, schools, the third sector and local businesses to discuss what actions we can all take together to improve the mental health of our local population, leading to the formation of a unprecedented local mental health partnership that will come together regularly to help tackle some of the key issues around mental health.

Key to the delivery of these new services, partnerships and ways of working are people – our staff, our service users, their families and carers – and providing them with an excellent experience of the Trust is essential to becoming the outstanding Trust we aspire to be. This year we expanded our popular Recovery College for All to a new site in the north of Birmingham, to add to our existing centres in Moseley and Solihull. Coupled with the launch of our Recovery for All Strategy, this is helping to promote messages of hope, recovery and opportunity to support service users, families and carers to lead fulfilling lives. In the Patient Led Assessments of the Care Environment (PLACE), our scores were once again amongst the best in the country, which is a testament to the excellent working between our estates and facilities and clinical teams, alongside service users and carers. Our Friends and Family Test shows that 90 per cent of service users asked would recommend our services and we also saw improvement in our community mental health survey, particularly in knowing who to contact in a crisis which had been a key area of focus.

We accept, however, that there are occasions when we do not provide care that is up to the high standards we set ourselves and we continue to make improvements to how we respond to complaints and learn from incidents.

We have around 4,000 fantastic staff across our organisation, who demonstrate unswerving compassion and commitment to providing the best care, in sometimes challenging circumstances, against a backdrop of unprecedented demand for mental health services. We celebrated their achievements during the year, not only through our own Quality and Excellence Awards, but also through a whole range of external awards nominations and successes. And we were extremely proud of Katharine Bird, Advanced Nurse Practitioner at our Ardenleigh site, when she was awarded an MBE in the Queen's Birthday Honours in June 2018. We marked the 70th birthday of the NHS in July with events and celebrations across the Trust, including our ever-popular AGM, which we live streamed for the first time in 2018 to enable service users and staff in our many sites to participate. This was introduced in response to feedback from service users who are detained in our inpatient wards and wanted the opportunity to participate.

While our staff survey showed small improvements in some areas, and our three fantastic staff networks have gone from strength to strength, it is clear that we still have much work to do to ensure that we truly live our Trust values and that all our staff in every area of the Trust feel safe at work and engaged and involved in changes being made. Staff engagement and involvement will be a key focus for us in the coming year as we strive to attract, recruit and retain talented, dedicated and compassionate people from our local communities to work with us. We know that having happy and engaged staff, as well as being important in itself, leads to a better experience for service users and carers.

Staff engagement and involvement was one of the areas highlighted in our latest CQC inspection, which took place in November and December 2018. The inspection report, published in April 2019, acknowledges that progress has been made since the last inspection in 2017 and highlights many areas of good practice. To be rated as 'good' for being caring and responsive is a reflection of the commitment of our staff to meet the individual needs of our service users and their carers. We recognise that there is still a great deal of work to do to move from our 'requires improvement' rating to 'good' and achieve the high standards we set ourselves across all areas of the Trust.

We welcome the CQC's recommendations and its support in helping us to achieve them, and look forward to working closely with our staff and local partners to make the changes required to improve the experience of people who work for and are cared for by us.

One of the ways we'll be doing this is through our Trust wide quality improvement programme, which we are delivering in partnership with the world-renowned Institute for Healthcare Improvement (IHI). We started this work with a diagnostic carried out by IHI in autumn 2018, which was followed by them working with the Board and senior leaders in the organisation. We now have more than 60 quality improvement projects under way, led by our staff, as part of a first wave of the programme. Around 80 colleagues have so far been trained in improvement science and tools with more to follow in September.

No overview of a year in the NHS would be complete without mentioning finances. We have maintained a strong financial track record over the years and we over-achieved against our annual plan in 2018/19. We were pleased to see the commitment to improving mental health services in the NHS Long Term Plan. It does, however, remain a significant challenge to strike an appropriate balance between the delivery of high quality services and financial sustainability, in the context of increasing demand. Fully engaging our staff and our local partners in quality improvement and looking at different ways of working and delivering services will be one of the key drivers of this in the years ahead.

As the year drew to a close, so did the tenure of our Chief Executive, John Short, who retired at the end of March after six years at the helm. We'd like to thank John for his leadership of the Trust since 2013, and for his uncompromising and passionate pursuit of parity of esteem for people experiencing mental ill health. We wish him a long and happy retirement.

Roisin Fallon-Williams
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 £248 million, a dedicated workforce of almost 4,000 staff and a range of local and regional partnerships, making this one of the most complex and specialist 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 69,000 service users, 2,500 of whom were cared for in our inpatient services and 1,900 who were supported by the Solihull Integrated Addictions Services. More than 20,500 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 Services 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	Risk of increased cost pressures due to: • potential for services to miss savings targets • scale of financial pressures relating to under-funding.
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 patients across all services and particularly in 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 specific risk of staff exposure to the use of legal highs within the prison remains however the risk is presently reduced due to the increased number of prison staff within the prison since the contract was taken back from G4S.
Electronic Prescribing and Medicines Administration (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. There is an expectation that this risk will reduce with an upgrade to the EPMA system in early 2019.
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.

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

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 2018/19

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 - 53 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 2019, we achieved 98.7 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 2019, we exceeded both targets with 96.8 per cent of service users beginning treatment within six weeks 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 2019, 100 per cent of urgent cases were seen within one week and 100 per cent of routine cases were seen within four weeks.

We have met the quarterly IAPT Moving to Recovery target of 50 per cent.

To date we are not meeting the reduction trajectories agreed with our commissioners for reducing out of area bed days. This is due to recognised whole system pressures across primary care, acute care, social care and mental health services. Joint discussions with commissioners and the local authority continue to take place to minimise and to reduce out of area placements.

New developments and achievements

Launch of the Recovery for All Strategy and expansion of Recovery College – Our Recovery College has been running since June 2016, and 911 learners attended Recovery College in 2018. The Solihull Recovery College was launched in 2017, and in 2018/19 the focus was on bringing college to our service users, carers and staff in North Birmingham. We now operate from three venues based in Moseley, Solihull and Erdington. Almost 50 experts by experience regularly contribute, either by co-facilitating sessions or through involvement in the advisory group. Seven new Recovery College sessions were launched in 2018 and evaluation shows that well over 90 per cent of learners find the sessions useful and would recommend them to others. In February we launched our Recovery for All Strategy, which built on previous initiatives, and was co-produced with staff, service users and carers through a number of workshops during 2018.

The strategy sets out a vision and set of principles for the promotion of recovery across the organisation to support service users, families and carers to lead fulfilling, flourishing lives through hope and empowerment.

Development of predictive analytics – Emerging from our work as part of the NHS Test Bed programme, a pilot began in November 2018 to test 'predictive analytics' within four of our community teams. The pilot involves the testing of a predictive algorithm developed in collaboration with our innovation partner, Telefonica Alpha. Based on historical Trust health data, the algorithm predicts service users that are at high risk of experiencing a mental health crisis within the next 28 day period. The introduction of this technology aims to predict incidences of crisis, flagging these cases to clinicians, which in turn allows them to proactively intervene to prevent the crisis occurring. Feedback to date has been positive from both clinicians and service users involved in the project. The pilot is establishing whether clinicians find this technology useful as part of their clinical decision making, alongside identifying whether crisis incidences have been reduced.

Further development of the Digital Ward app – In 2017 our Trust was announced as one of seven global digital exemplars (GDEs) for mental health. We have worked tirelessly to improve the use of existing technology and the development of new innovations that all aim to put service users at the heart of services and care. This has included the creation of a Digital Ward app that enables nurses to enter therapeutic observations on a hand held mobile device, replacing cumbersome written notes and recording information in real time and linked to our electronic clinical record. During 2018/19 we completed the second phase of this programme, which was to design, test and transfer physical observations to this system. The app enables more time for direct patient care and has been highlighted through a film commissioned by NHS England that will help to share the learning and benefits from this project with other NHS organisations.

Veterans' Complex Treatment Service – During 2018/19 we launched a new service to care for veterans in the West Midlands with complex mental health problems, including post traumatic stress disorder (PTSD), which are attributable to military services and have not been resolved earlier in their care or support pathway. The Complex Treatment Service (CTS) has proved successful in achieving its commissioned activity levels during the year and as a result has submitted a business case for additional funding to expand the service.

FCAMHS community service – In April 2018 we launched a new service to provide a specialist forensic community mental health service for young people in the West Midlands with high risk behaviours such as violence, self-harm and internet offending. This builds on our successful existing 'Youth First' service and involves 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.

Addictions services in Solihull and Wolverhampton – In August 2018 our Solihull Integrated Addictions Service (SIAS) partnership was successful in winning a four year contract worth nearly £2m a year to continue to provide substance misuse services. SIAS is an innovative partnership between our Trust, Welcome, Aquarius, Changes UK and Urban Heard.

The revised service model builds on existing capabilities to ensure service users' needs are met at all stages, with key features being prevention and early intervention, pathways to self-sustaining recovery, system integration to manage and reduce demand, and targeting available resources where they can have most impact. In 2017/18 the Recovery Near You (RNY) substance misuse partnership was successful in retaining the contract for the service in Wolverhampton. Recovery Near You, is an established partnership led by Nacro, with our Trust and Aquarius. The service's key principles are opportunity, empowerment, social support and recovery and the service model includes increased integration with partners such as mental health, primary care, social care and criminal justice as well as increased prevention, outreach and recovery focus.

Non-medical diagnosis of dementia – We identified an opportunity to upskill some of our psychologists in our Memory Assessment Services (MAS) to enable them to start diagnosing non-complex dementia patients. This followed discussion with, and agreement by, our Medical Advisory Committee and local and Trust Clinical Governance Committees. This will only happen within the MAS teams and will be closely supervised by the MAS consultant. The psychologists involved have received training in diagnosis of dementia. Multi-disciplinary team discussions take place in MAS teams when patients are seen by the nurse practitioners and other senior practitioners. Subsequent discussions are held with doctors to confirm diagnosis. It was felt that this non-complex group of dementia patients can benefit from quicker diagnosis if psychologists are able to make the diagnosis.

New model in primary care in East Birmingham – A range of partners in Birmingham and Solihull are working with a local GP partnership to trial a new way of working that will mean better mental health care for local people, provided in the right environment, at the right time, close to home, by the most appropriate professional. The pilot of a new integrated place-based primary care service for people with mental health problems is initially focused on patients served by the Omnia Practice in East Birmingham. At a weekly multi-disciplinary team meeting (MDT), professionals from the NHS and a range of local statutory and voluntary sector services discuss, plan and deliver care for patients put forward by GPs at the practice. The MDT considers the needs of the individual relating to housing, employment, money or relationships alongside mental health difficulties, and agrees a plan of action that might range from signposting the patient to local services through to a full case managed wrap around approach.

New hub for Solihull at Maple Leaf Centre – During the year we began the refurbishment of the Maple Leaf Drive site that will become the new community mental health hub for Solihull. This is in line with our 'New Dawn' programme and was outlined in Solihull CCG's 2016 consultation on the redesign of mental health services in Solihull. Renovation work began in October 2018 and the entire building is being refurbished to provide a modern, comfortable, purpose built environment for service users and their carers. Service users, carers and governors have been involved in choosing the colour scheme and decoration and in deciding that the site will be known as the Maple Leaf Centre. Further engagement events are planned with service users, carers and governors to help with choosing the furniture.

Plans for developments at Reaside and Highcroft – We have embarked on planning for two major capital developments at our Reaside and Highcroft sites, to upgrade facilities so that we have the right environment for service users and a good working environment to support our staff in delivering great care.

This has included setting up clinical reference groups to develop the new clinical models for the services, which will then help us decide on the design of the buildings. Teams have started to engage staff, service users and local stakeholders in the plans from the outset. Our clinicians have visited, or are planning to visit, some of the most cutting edge and innovative secure and inpatient services in the country to find out how they deliver care and inform our plans. Alongside this, sources of external funding for these developments are being explored.

An award winning Trust – During the year we have celebrated numerous awards for our staff and teams. These included:

- At the Royal College of Psychiatrists Awards, Katy Chachou was named winner in service user contribution category.
- Our Research and Innovation team was recognised in three categories at the Clinical Research Network Awards, for 'Team of the Year', 'Best Overall Performance' and 'Local Investigator of the Year' for Prof Hugh Rickards.
- MERIT was recognised at the WMAHSN Meridian Celebration of Innovation Awards.
- Our Liaison and Diversion Team was a winner at the Howard League Awards.
- Our Estates and Facilities Team scooped a Health Estates and Facilities Management Award.
- At the West Midlands Combined Authority Mental Health Commission Thrive Awards we had seven finalists in the Birmingham and Solihull categories; our Liaison and Diversion Team and Beresford Dawkins from our Community Engagement Team took home the two available awards in these categories.
- Reach Out was Highly Commended in the Acute or Specialist Re-design category at the Health Service Journal Awards.
- Two of our apprentices were shortlisted for awards; Badar Anwer received a Bronze Awards in the Health Heroes Awards and Sheroze Arif was highly commended in the Asian Apprenticeship Awards.
- Community Engagement won the Most Innovative EDI Initiative category in the National Centre for Diversity Awards 2019 for the 'In Conversation…' series of events.
- In the Leading Healthcare Awards, we were named winners for the Digital Ward Physical Observation App and the MERIT programme.
- Nicola Jenks was a finalist in the Mentor of the Year category at the Student Nursing Times Awards.
- Our Human Resources Team has been nominated in two categories at the National Healthcare People Management Association Awards, for excellence in partnership working with trade unions and innovation in HR practices.

We were very proud that, following her recognition in the Trust's 2017 Quality and Excellence Awards, Advanced Nurse Practitioner Katharine Bird went on to be awarded an MBE in the Queen's Birthday Honours in June 2018 for her work in supporting young people at our Ardenleigh site.

Key partnerships and alliances

Birmingham and Solihull Sustainability and Transformation Partnership

We have made an active contribution to the refresh and further development of the Birmingham and Solihull Sustainability and Transformation Partnership (STP) strategy. We have supported engagement with key stakeholders such as local leaders, non-executive directors and governors. Our Trust was well-represented at an engagement event held in December 2018, where we also presented the Adulthood and Work STP workstream. We are fully involved in the STP's work to improve the care and experience of older people in Birmingham and have been the first of the STP partners to receive external support for developing social value working, for which we will act as a role model and leader to help others adopt good practice.

Reach Out and New Care Models

Reach Out is a partnership between our Trust, Midlands Partnership NHS Foundation Trust, St Andrew's Healthcare and NHS England and is part of the national New Care Models programme, which is focused on devolving responsibility for secure care services from a national to a regional level. The partnership has been 'live' for two years in pilot form and we are now entering year three. Two of the main aims of the New Care Models in secure care are to provide care closer to home and in the least restrictive setting possible. The partnership has delivered on this, successfully reducing the number of service users in inpatient beds across the region and increasing the number able to receive their care in the community. This has been achieved through the development of an intensive forensic community support offer that is able to support an increasing number of patients to live more independently. The partnership has also reduced the number of service users receiving care in out of area inpatient beds.

We are now working alongside colleagues across the region on the development of innovative new care models for eating disorders and Tier 4 CAMHS.

Mental health round table and launch of mental health partnership

In April 2018, in partnership with the West Midlands Mayor and Grant Thornton, we hosted a round table discussion entitled 'Mental Health, Everyone's Business' that brought together leaders from the NHS, local authorities, universities, schools, third sector and private sector to discuss what actions we can all take together to improve the mental health of our local population. This led to the publication of a thought piece and the establishment of a Mental Health Partnership which will come together four times during the year to talk about the key issues facing us. The first session on suicide prevention was attended by over 40 agencies including representation from health providers and commissioners, Network Rail, British Transport Police, local universities, schools, local government, local businesses, charities, the Coroner's office, sports partnership, Public Health England, migrant and refugee centre, drug and alcohol services, school leaders, service users and carers. The outcome of the session will be written up as a local thought piece and will contribute to the development of the Birmingham suicide prevention strategy and the refresh of the Solihull strategy.

MERIT

The MERIT programme consists of the five NHS trusts in the West Midlands conurbation who provide specialist mental health services, and was originally one of 50 ‘vanguards’ supported by NHS England to deliver new models of care. The collaboration has continued its commitment to work closely beyond the NHS England funding. Key achievements include the development and introduction of the Electronic Health Record Viewer, allowing clinicians to see patient information from neighbouring MERIT trusts to improve patient care and avoid patients having to tell their story multiple times, and the establishment of a coordinated bed management function across the MERIT trusts supported by an electronic bed viewer, to facilitate the most effective use of available beds across the West Midlands and avoid out of area placements. The partnership has also developed recovery practices with the use of Re-focus and ReQoL, as well as delivering Mental Health First Aid training and establishing a staff training passport across MERIT trusts. In line with the aspiration of the vanguard programme, learning has been shared with other health systems. While managing a complex programme across organisational boundaries has at times been challenging, staff and service users have been positive about having shared goals and a shared vision, leading to better joint working across the mental health trusts. We are now looking to expand MERIT to all mental health trusts in the region.

New funding awarded during the year

In addition to the new SIAS contract mentioned earlier, as part of NHS England’s Mental Health Service Review, work has been ongoing over the past year to consider the pathway through women’s secure care and how this can be improved. One of the proposed improvements is development of a blended low and medium secure service alongside the development of a trauma-informed model of care. NHS England sought bids from providers to identify three sites to pilot this model. Our bid submitted in November was successful and we will receive c£0.2m funding in 2018/19 and c£1.2m funding in each of 2019/20 and 2021/20 to pilot our new service model at Ardenleigh. This will help us manage our bed capacity better, as well as improving patient experience through reduced length of stay in hospital, less transitions of care, repatriation closer to home, improved ward environment and climate, enhanced programme of enrichment activities and more peer support.

Research and Innovation

It has been another successful year for research and innovation in the Trust. We brought in a slightly increased amount of external funding, amounting to £2.03m. Regionally, we still attract the highest amount of Research Capability Funding (RCF), totalling £105k.

We have developed a strong partnership with the Institute of Mental Health at the University of Birmingham, appointing a Professor of Psychiatry with a special interest in mood disorders and a reader in addictions. We have submitted grant applications in excess of £6.9m and have been successful in being awarded £1.02m of grants in year with the outcome for pending grants worth in excess of £3.44million income. We have collaborated with other centres, have been successful with grants exceeding £4m and will continue the momentum going into the new financial year. We have also supported 21 clinicians, five more than last year, to undertake the role of principal investigator (PI), predominantly on National Institute for Health Research (NIHR) portfolio trials; 14 of these were completely new to the role.

Our activity continues to contribute to the development of clinical guidelines and is influencing policy on both a national and international basis. This includes: developing guidelines on the treatment of tics in people with Tourette Syndrome; guidance on the use of the ASPIRE VNS (Vagus Nerve Stimulation) device which is cardiac gated and a better form of treatment for partial responders; developing local services that ensure women of different ethnicities have equal access to perinatal mental health services, and; participation in the establishment of a global project to ensure equal access for disease modifying drugs in Huntington's Disease. In addition, we have produced 88 publications in peer reviewed contributed chapters to books and presented posters and talks at a number of high profile conferences and events.

In 2018/19 we have:

- exceeded our NIHR recruitment target by almost 40 per cent (1,034 patients recruited against a target of 725)
- opened more commercial studies than in previous financial years, including opening the first commercial study in eating disorders
- remained a top recruiting site for commercial Epilepsy research delivering all studies to time and target and being the top recruiting site for a patient preference study in epilepsy monotherapy
- ensured that 100 per cent of commercial studies recruited the first participant within 40 days post approval; 73 per cent achieved for non-commercial studies
- contributed to a 22 per cent increase in the West Midlands recruitment to dementias, mental health and neuro studies
- provided 25 per cent of the West Midlands volunteers registered on the JDR (Join Dementia Research) campaign during 2018/19.

We have supported over 90 different research teams during the year, across all stages of the research pathway from protocol support, costing advice, through to regulatory approvals and delivery set up. There were 43 research studies approved, 10 more than last financial year.

Financial performance

The Trust wholly owns a subsidiary Summerhill Services 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 with the need to maintain standards of safety in and quality of services, against a backdrop of significant increases in demand and a savings target of 3.9 per cent. In addition to an inflationary increase of 0.1 per cent from commissioners in line with national guidance, we were successful in securing new income from Commissioners (eg Perinatal Mental Health). We have, however, 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 £7.1m of savings against a plan of £9.6m (74 per cent of the requirement). The shortfall of recurrent savings has been incorporated into plans for 2019/20.

Our year end position is an operational income and expenditure surplus of £3.7m before taking into account any exceptional items, compared to a planned surplus before exceptional items of £1.9m.

This included £1.7m of incentive funding from NHS Improvement, which was as a result of outperforming the Trust control target of £1.9m by £62k. The group shows a deficit of £5.2m including exceptional items, as a result of a £8.9m 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 2018/19 and 2017/18

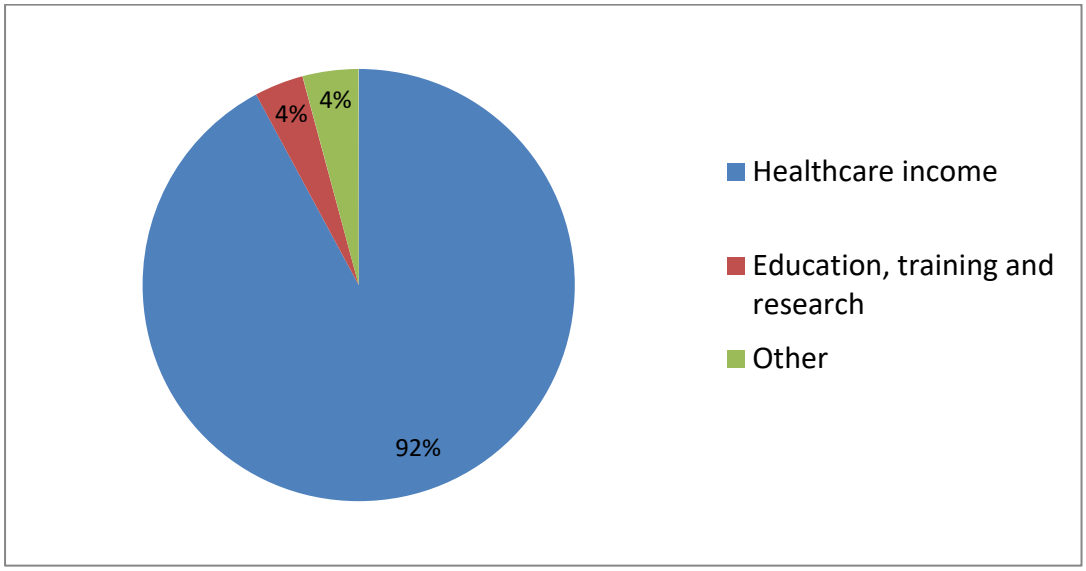
	2018/19 £'000	**2017/18 £'000**
Income from activities	222,533	210,765
Other operating income	25,351	24,568
Total income	247,884	235,333
Operating expenses	(229,413)	(217,271)
EBITDA	18,471	18,062
Capital financing costs	(14,634)	(13,112)
(Impairments)/revaluation	(8,897)	4,368
Profit/(loss) on asset disposal	0	(15)
Corporation Tax	(143)	72
(Deficit)/surplus including exceptional items	**(5,203)**	**9,375**
Exceptional items:		
(impairments)/Revaluation	(8,897)	4,368
Costs of exceptional restructuring	0	0
Operating surplus excluding exceptional items	**3,694**	**5,007**
Operating surplus margin	1.5%	2.1%
EBITDA margin	7.5%	7.7%

Income

In the financial year 2018/19 the group generated income of £248m. We had an income inflator applied by our commissioners to our healthcare income contracts of 2.1 per cent. This was in line with all NHS providers.

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

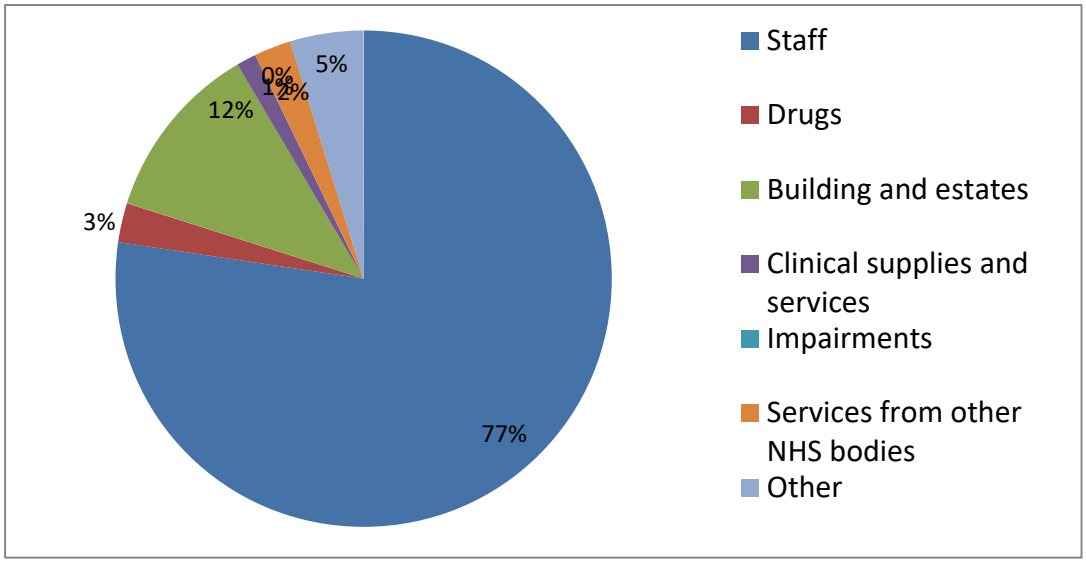
Where the Trust's income comes from – 2018/19



Expenditure

The chart below shows that our staff represent a huge majority of our expenditure as well as out most valuable asset. 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 2019/20.

What expenditure was incurred by the Trust – 2018/19



Cash flow

At the end of the financial year we have £17.7m cash available to us and remain in a strong position liquidity-wise. With interest rates falling we did not make any financial investments this financial year.

Overview of capital investment and asset values

We invested £7.9m in capital developments during the year consisting of £4m in our IT infrastructure and systems, £1.2m in backlog maintenance and ensuring our buildings complied with statutory standards and £2.8m in other projects to modernise our estate and ensure it is fit for purpose.

The year-end revaluation of the estate which, in line with the previous year, was conducted on a Modern Equivalent Asset (MEA)-alternative site valuation methodology, resulted in an overall impairment charged to the income and expenditure account of £8.9m and an overall reversal of impairments charged to the revaluation reserve of £7.1m. This is a technical adjustment which has no impact on our cash but ensures that the true value of our assets is recorded in the balance sheet, assisting 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 the Trust's Finance, Performance and Productivity Committee and Operational Management Team.

  The full key performance indicator (KPI) report includes 42 measures, comprising:

  - national indicators as outlined in NHS Improvement's Single Oversight Framework

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

  - remaining 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 care programme approach (CPA) seven day follow up, did not attend (DNA) rates, community mental health team diagnosis recording, service users on the care programme approach 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 and twelve months, length of stay, bed occupancy, delayed transfers of care and emergency readmission rates within 28 days of discharge.

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

The aim is to review performance metrics by exception and have an increased focus on service led priorities that cover:

- demand and capacity
- understanding the above in conjunction with staff experience
- triangulating quality, activity and resources as part of the patient experience.

- 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.

- Service specific profile reports (SPRs) are 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.

  They also include 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 inform local discussions on understanding variation to aid learning and inform the Trust's improvement agenda.

- Development of an integrated dashboard which aims to bring together a holistic view and provide a balanced understanding of quality, performance, finance and workforce measures so we can see the relationship between the different elements to enable understanding of dependencies and to identify the key areas for improvement across the four domains supporting the Trust strategy - Quality, People, Sustainability and Performance.

  A draft version is currently being shared at our Finance, Performance and Productivity Committee meeting. Further development is planned, including a service level view to be in place by quarter 3 of 2019/20.

In 2018/19 we have monitored our quality goals of safety, experience and effectiveness against the following indicators:

- Development and implementation of a clinically driven and consistent approach to quality improvement across the Trust.

- Provision of services which ensure that mental and physical healthcare needs are assessed and given equality of consideration when planning and delivering care.
- Reduced mortality through co-produced crisis plans, learning from mortality case note reviews and a reduction in the number of suicides.
- Embedding of a culture of least restrictive practice with reduced incidents of prone restraint, seclusion and physical assault.
- Promotion of recovery, co-production and family, carer and service user involvement.

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 2018/19

The Trust, working with its subsidiary Summerhill Services Ltd (SSL) as well as its PFI partners and external landlords, has continued to achieve positive results by reducing further its reliance on fossil fuels and improving its resource management. In 2018/19 we did consider applying for Department of Health grant funding to support LED replacement projects, but unfortunately this application never came to fruition as the required return on investment requirements, given our already well maintained and efficient estate, were such that the projects would not have been granted the funding. Instead we continue to underpin our redevelopments and refurbishments and new builds with, where we can, environmentally friendly and 'greener' solutions.

Please note that the detail in this report is for all Trust sites, including SSL sites, regardless of tenure of occupancy.

Carbon management

Performance against core sustainability components during the 2018/19 financial year has been strong. Our CO_2 equivalent performance of 9,943 tonnes represents a cumulative reduction of nearly 20 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	779	10	10,547
2018/19	9,209	723	11	9,943

We are now working towards the next statutory target for CO_2 reduction of a 34 per cent by 2020 (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)

In the 2018/19 financial year, 98 per cent of the waste produced by or within BSMHFT 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. This is a significant achievement and keeps the Trust very close to that aspirational zero per cent landfill milestone that many are trying to achieve.

Waste	Non-financial data 2017/18	Non-financial data 2018/19
Total Waste Arising	930 Tonnes	1,013 Tonnes
Waste sent to Landfill	18 Tonnes	26 Tonnes
Waste Recycled	551 Tonnes	618 Tonnes
% of Waste Recycled / Recovery	98%	98%
Waste Incinerated	360 Tonnes	369 Tonnes

	Financial data 2017/18	Financial data 2018/19
Total Expenditure on waste disposal	£159,843	£165,899

Joint market testing with our PFI partners will be undertaken for domestic, clinical and other hazardous waste during the 2019/20 financial year with new contracts anticipated to commence April 2020. The impact on service type and costs cannot be reported at this stage as in this financial climate the Trust will be seeking a compliant and effective service that delivers best financial value.

Finite resources (electricity, gas and water)

The table and supporting graphs below demonstrate:

- **Gas consumption and costs**

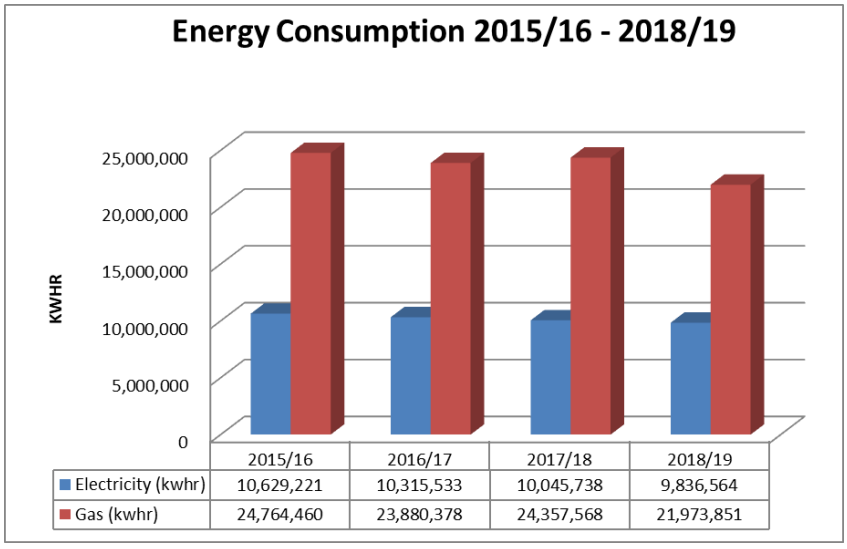
    - Gas consumption in 2018/19 was 10 per cent lower than in 2017/18. This decrease being largely down to the much milder winter but also being attributable to the control mechanisms in place within Estates and Facilities to reduce consumption by ensuring areas are not overheated or heated beyond that of frost protect when not needed.

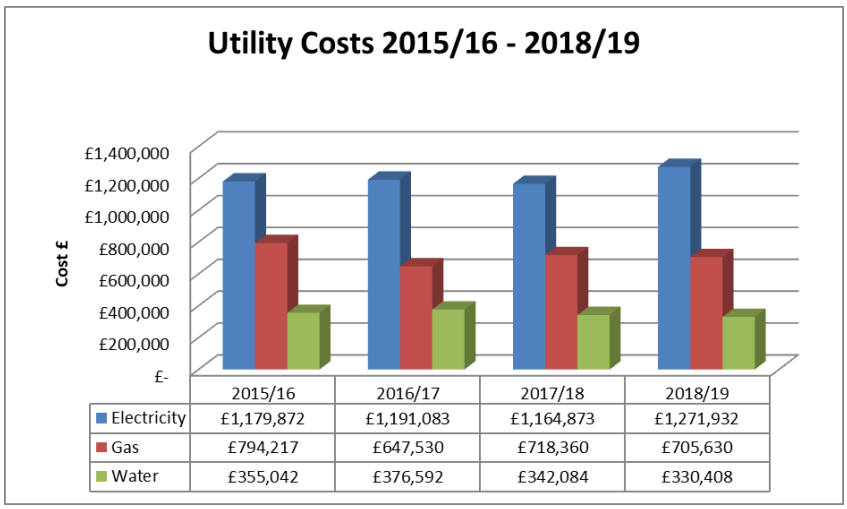
    - The reduced gas consumption in 2018/19 has been mitigated financially by the impact of the increase in energy prices experienced during the financial year. Indeed the £703,630 expenditure outturn was 1.5 per cent lower than in 2017/18.

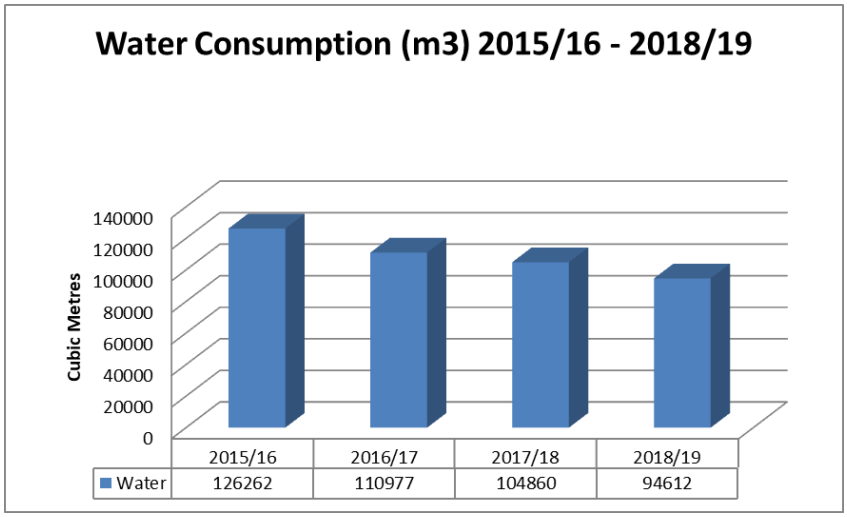
- **Electricity consumption and costs**

    - Electricity consumption in 2018/19 was 2 per cent lower than in 2017/18. This decrease would have been greater had we not all benefitted from such an abnormally hot and long summer with the resulting additional air conditioning and cooling requirements. This decrease also helped to demonstrate the added benefits associated with the environmentally (green) linked improvements over the past few years.

    - The electricity costs for 2018/19 were 9 per cent higher than in 2017/18, this being due to external energy price increases associated with the non-commodity costs of supplying electricity rising steadily. That noted, however, given the predicted budget lift of 13 per cent at the start of the financial year it could be suggested that the 9 per cent increase still represents a strong end point.







It should be noted that energy prices are increasing year on year. On average across gas and electricity over 50 per cent of the final price of energy consists of taxes, transmission and distribution charges and other supply charges, and less than 50 per cent of the final delivered energy price actually relates to the commodity itself.

By way of example, when publicised in the media that energy prices may have decreased because of cheaper crude oil this does not always translate to the final delivered price, as the non-commodity costs are accelerating every year and don't show any sign of slowing down.

Therefore predicting and planning for year on year increases in the final delivered energy cost is the only prudent way to manage this commodity.

Priorities and achievements

Our Trust has achieved national recognition and awards over the past few years for the significant progress we have made in addressing the sustainability agenda. In 2018/19 we received an Excellence in Sustainability reporting awarded by NHS Improvement and Public Health England – a significant achievement.

We have by nature of our success 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, our Trust needs to continue to:

- invest in environmentally efficient and sustainable technologies, products and services. With two new extremely large new developments in the pipeline time is of the essence to include within design specifications and output parameters a new development that is also fit for purpose from an environmental and sustainability perspective

- work in partnership with key stakeholders on promoting 'greener' travel initiatives with a particular focus on the A38 corridor and the forthcoming 2020 Clean Air Zone for Birmingham

- integrate and embed the ethos of sustainability within the estates strategy, SSL strategy and service delivery strategies

- be innovative in the way we continue to drive down resource wastage, continually developing a range of tools and materials to promote our commitment to sustainability and engage with staff and service users.

- contribute towards the national 34 per cent carbon reduction target by 2020

- start to plan and prepare for the review in 2020 of the overarching Sustainable Development Environmental Strategy.

The Trust continues 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-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 is involved in a number of partnerships and initiatives across our communities. Once again in summer 2018 this included community engagement family fun days across Birmingham and Solihull. Some of the other highlights of our work within the community during 2018/19 are summarised overleaf:

Working in Collaboration with the Community: Understanding the Caribbean Mental Health Experience – The Community Engagement Team hosted this seminar on 20 September 2018 with Catalyst 4 Change, who have worked closely with our Trust. Guest speakers included Vanley Burke, Renowned Black Cultural Photographer and Artist Alicia Spence, Director of The African Caribbean Community Initiative (ACCI).

The aim of the seminar was to increase knowledge and understanding of Caribbean communities' history and culture in the West Midlands, understand how mental health is conceptualised by Caribbean communities, increase understanding of culturally sensitive approaches and services to improve mental health and well-being of Caribbean Communities, and encourage networking opportunities between statutory staff and organisations/communities.

Mental Health and the Jewish Community – A seminar held on 23 October 2018, focused on sharing information about the Jewish community in Birmingham, and was hosted by the Birmingham Central Synagogue. This was a great opportunity for staff and service users to gain new information, perspectives and contacts.

Elders Project Launch Event – This successful launch event took place on 31 October at the Tamarind Centre. This project gives us the opportunity to collaborate with several partners to deliver complementary programmes and activities relating to mental and emotional resilience. The aim is to use forum theatre methods to train staff and assist service users to explore the issues relating to mental health, education and criminal justice that affect black men in day to day living. The event invited elders who have expressed an interest in the Elders Programme to familiarise themselves with the secure population and the secure setting, in preparation for future recruitment as volunteers. Participants joined from the local communities from within the faith, sport and music industries.

Anti-bribery

We are committed to full compliance with the Bribery Act 2010 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 was updated in January 2019 and 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. Protection of human rights is covered in our new Equality, Inclusion and Human Rights Policy, which was ratified in July 2018 and superseded the previous Equal Opportunities Policy. Equality and human rights analysis is considered as part of all papers submitted to the Trust Board and its committees.

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:

Roisin Fallon-Williams, Chief Executive
Birmingham and Solihull Mental Health NHS Foundation Trust Date: 22 May 2019

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 2018/19 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. Between 2013 and 2018, Sue represented mental health trusts on the Board of NHS Providers, where she was 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 (until 29 March 2019)

John Short was Chief Executive of the Trust from 1 April 2013 until his retirement at the end of March 2019. 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. John announced his resignation on 1 August 2018 and retired from the Trust on 29 March 2019.

Roisin Fallon-Williams, Chief Executive (from 29 March 2019)

Roisin Fallon-Williams joined the Trust as its designate Chief Executive on 1 March 2019 became the Accountable Officer on 29 March 2019. Roisin is a Registered Learning Disability Nurse who spent much of her early career in clinical roles in and around Hertfordshire, within mental health and learning disability NHS organisations. She took up her first Board director role in 2002 at Hertfordshire Partnership NHS Trust, and since then has held a variety of Board roles with a wide range of responsibilities including seven years at Coventry and Warwickshire Partnership NHS Trust. Most recently she was Chief Executive at Norfolk Community Health and Care NHS Trust, where she was Chief Executive for four years before leaving in May 2018 to take a career break. During her time there, the Trust achieved an ‘Outstanding’ rating from the Care Quality Commission.

Charlotte Bailey, Executive Director of Strategic Partnerships

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.

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.

Dave Tomlinson, Executive Director of Finance

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.

He 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.

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 Linda Cullen, Non-Executive Director

Dr Linda Cullen was appointed as a non-executive director from 1 January 2019. Linda has worked as a Consultant Child and Adolescent Psychiatrist for 25 years in a wide variety of settings across the Midlands. She is currently a locum consultant in the NHS and also a second opinion doctor for the Care Quality Commission. She has worked closely with colleagues in child and adult services, using research and evidence based practice in developing novel services. Dr Cullen helped to develop Early Intervention in Psychosis services across Birmingham and acute and high dependency child and adolescent mental health services (CAMHS), including one of the first CAMHS acute admission wards in the UK. She has also been active as a trainer, tutor, and mentor and for several years in clinical lead and director roles with professional line management responsibilities.

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 was also a councillor representing the Brandwood ward on Birmingham City Council and chaired the Council's conservation and heritage panel, the wholly owned subsidiary Acivico, the ICT joint venture with Capita and the Standing Advisory Council on Religious Education. Barry is Chair of the Trust's Finance, Productivity and Performance Committee.

Gianjeet Hunjan, Non-Executive Director

Gianjeet Hunjan was appointed as a non-voting associate non-executive director on 1 September 2015 and was appointed as a 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. Gianjeet is Chair of the Trust's Audit Committee.

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. Waheed is Chair of the Trust's Mental Health Legislation Committee and since February 2019 has been Senior Independent Director.

Joy Warmington, MBE, 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, appearing in the Economist, Daily Telegraph, and Health Service Journal in addition to numerous appearances on BBC radio and television. Joy was awarded an MBE in January 2019 for her contribution to healthcare and the community. Joy is also Vice Chair of the Trust.

Dr Nerys Williams, Non-Executive Director

Dr Nerys Williams - who was appointed as a non-executive director on 1 December 2011 - is a qualified doctor specialising in the field of occupational health medicine. She has worked in both clinical, regulatory and strategy/health policy roles including work for Health and Safety Executive and Department for Work and Pensions. Nerys also holds a number of roles relating to her professional qualifications in the NHS, local government and education fields. Nerys came to the end of her term on 30 November 2018 and during her tenure acted as Chair of the Charitable Funds Committee for the Trust and was also the Senior Independent Director until her departure from the Trust.

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 non-executive director to replace a non-executive director who left the Trust in December 2018, and a new chief executive to succeed John Short, who retired from the Trust on 29 March 2019.

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 2018/19 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 2018/19

Dates	**25/04/18**	**30/05/18**	**27/06/18**	**25/07/18**	**26/09/18**	**24/10/18**	**28/11/18**	**30/01/19**	**27/02/19**	**27/03/19**
Sue Davis	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
John Short	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Brendan Hayes	✓	O	✓	O	✓	✓	✓	✓	✓	✓
Hilary Grant	✓	✓	✓	**O**	✓	✓	✓	✓	✓	✓
Dave Tomlinson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sue Hartley	✓	O	✓	✓	✓	✓	✓	✓	O	✓
Charlotte Bailey	O	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nerys Williams (left December 2018)	✓	✓	✓	✓	✓	✓	✓			
Joy Warmington	O	✓	✓	✓	✓	✓	✓	O	✓	O
Barry Henley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Waheed Saleem	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gianjeet Hunjan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Russell Beale	O	O	✓	✓	✓	✓	✓	O	✓	O
Linda Cullen (Joined January 2019)								✓	✓	✓
Roisin Fallon-Williams (joined March 2019)										O

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, Waheed Saleem, 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 Governors' 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.

Executive directors 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 2018/19 financial year, the Remuneration Committee received the notice of the retirement of John Short, Chief Executive and agreed the appointment of Roisin Fallon-Williams, who joined the Trust on 1 March 2019. This appointment was approved by the Council of Governors. The committee agreed to a handover period of one month between the chief executives.

Dr Nerys Williams, Non-Executive Director, came to the end of her term on 30 November 2018. The Nomination and Remuneration Committee appointed Dr Linda Cullen in her place. The standard length of appointment for a non-executive director is three years, and Dr Cullen commenced her term on 1 December 2018.

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 2018/19 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 section of this annual report.

The Trust has also had an external well-led review undertaken by the Good Governance Institute and commenced its quality improvement programme with the Institute for Healthcare Improvement (IHI).

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 (1 April 2018 – 30 November 2018)
- Linda Cullen – Non-Executive Director (1 December 2018 – 31 March 2019)
- 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 2018/19

Date	April 2018	May 2018	July 2018	Oct 2018	Jan 2019
Gianjeet Hunjan	✓	✓	✓	✓	✓
Barry Henley	✓	✓	✓	✓	✓
Nerys Williams	✓	✓	✓	✓	
Waheed Saleem	N	✓	N	N	O
Russell Beale	N	✓	N	N	✓
Linda Cullen					✓

O = apologies given ✓ = attended meeting P = partial N = Attended another committee due to clash

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.

The audit fee for the year ended 31 March 2019 was £50.6k (2017/18: £49.7k) for the Trust's annual report, £7.4k (2017/18: £7.3k) for the Trust's quality accounts, nil (2017/18: £3k) for additional payroll controls and new models of care and £8.0k (2017/18: £8.8k) for Summerhill Services Limited, totalling £66.0k excluding VAT (compared to £68.8k for the year ended 31 March 2018). This was the fee for an audit in accordance with the Audit Code issued by NHS Improvement in December 2014.

The following threats and safeguards are in place to ensure Auditor objectivity and independence. PricewaterhouseCoopers LLP does not support the Trust 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. It 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).

Directors of the Trust have confirmed there is no relevant audit information of which the auditor is unaware and that directors have taken steps to make themselves aware of any relevant audit information and to establish that the auditors are aware of the information.

We have appointed new external auditors, Mazars, who will commence their audit services from the 2019/20 financial year for three years.

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 Lives
All NHS Trusts are obliged to account for properties in their financial statements by including appropriate values and depreciation charges and do so in a manner consistent with applicable International Financial Reporting Standards (IFRS), government and the Royal Institution of Chartered Surveyors (RICS) standards and guidance. This requires the application of sound, professional judgement and estimates. RICS Valuation – Professional Standards January 2014 UK Guidance provides the economic life of an asset is determined via the Depreciated Replacement Cost (DRC) valuation to arrive at the Depreciable Amount. The DRC can vary from the useful economic remaining life for accounting depreciation (useful economic life - UEL) because the criteria are not identical. The latter (UEL) requires clarity regarding the future intended usage and service delivery lifespan and the Trust appoints a District Valuer to provide it with a professional opinion in this matter. This can give rise to varying interpretations of what will and will not be accepted by different parties. RICS has recently reviewed its guidance relating to the valuation and remaining life of properties. This had the effect of preventing valuers from providing 'accounting' lives alongside their valuation estimates and (shorter) 'valuation' lives. The Trust used the 'accounting' lives to calculate depreciation in 2017/18 and 2018/19, using lives provided by the District Valuer in its valuations at 31 March 2017 and at 31 March 2018 respectively. As the impact of this change is below the agreed level of materiality, as determined by the Trust's auditors, the Trust has chosen not to correct its accounts to reflect the impact on its 2018/19 accounts. The Audit Committee considered the argument made by the Trust's auditors and decided that the adjustment should not be actioned in the accounts. The Audit Committee appreciated and fully understood the auditors' views and took them into account in agreeing the accounting treatment.

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 2018/19.

Better payment practice code

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

Better Payment Practice Code performance

	2018/19	2018/19	2017/18	2017/18	2016/17	2016/17	2015/16	2015/16
	Number	£'000	Number	£'000	Number	£'000	Number	£'000
Total NHS invoices paid in the period	380	8,104	498	9,805	529	10,053	521	8,726
Total NHS invoices paid within target	373	8.080	484	9,644	515	9,903	474	8,403
Percentage of NHS invoices paid within target	98.2%	99.7%	97.2%	98.4%	97.35%	98.51%	90.98%	96.30%
Total non NHS invoices paid in the period*	37,004	90,184	35,557	84,885	25,455	91,931	56,875	58,559
Total non NHS invoices paid within target	35,326	88,726	33,392	83,409	33,915	90,500	53,321	53,655
Percentage of non NHS invoices paid within target	95.5%	98.4%	95.4%	98.3%	95.66%	98.44%	93.75%	91.61%

*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 2017/18 and 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 2018/19 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 work has been developed for the past five years, with a year on year improvement in the 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, the Trust implemented an electronic system for staff to report their annual declarations.

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. 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 2018/19 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 for 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 2018/19

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

- John Travers – Staff Non-Clinical Governor– elected through a contested election in July 2018.
- Ed Freshwater – Staff Non-Medical Clinical Governor – elected through a contested election in July 2018.
- Dr Jon Kennedy – Staff Medical Governor – elected unopposed in July 2018.
- Maureen Johnson – Carer Governor – re-elected unopposed in March 2019.
- Natasha Day – Carer Governor – elected unopposed in March 2019.

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 and the Clinical Commissioning Group posts.

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

- Councillor Alan Rebeiro (Solihull Metropolitan Borough Council) – appointed July 2017, stepped down November 2018.
- Dr Aqil Chaudary (NHS Birmingham and Solihull CCG) – reappointed December 2016 and stepped down June 2018.

Our governors 2018/19

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, re-elected unopposed in March 2019
Anthony Brookes – elected January 2015, re-elected unopposed in January 2018
Natasha Day – elected unopposed in March 2019
Michelle Long – re-elected unopposed January 2018 and stepped down in January 2019.

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 Jon Kennedy (Clinical medical) – elected unopposed in July 2018
John Travers (Non-clinical) – elected through a contested election in July 2018
Ed Freshwater (Clinical, non-medical) – elected through a contested election in July 2018.

Stakeholder
Jim Chapman (Birmingham City University) – appointed September 2017.
Maureen Smojkis (University of Birmingham) – reappointed in March 2018.
Cllr Mick Brown (Birmingham City Council) – reappointed September 2016.
Cllr Alan Rebeiro (Solihull MBC), appointed July 2017, stepped down in November 2018.
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, stepped down in June 2018.

Council of Governors attendance 2018/19

	May 2018	July 2018	Sept 2018	Nov 2018	Jan 2019	Mar 2019
Governor attendance						
Khalid Ali	✓	✓	O	✓	✓	O
Natalie Allen	O	O	✓			
Anthony Brookes	✓	✓	✓	✓	O	✓
Mick Brown	✓	O	✓	O	O	✓
Peter Brown	✓	✓	O	✓	✓	✓
Jim Chapman	O	✓	✓	✓	O	✓
Robert Dalziel	✓	✓	✓	✓	✓	✓
Ed Freshwater			✓	O	O	O
Maureen Johnson	✓	✓	✓	✓	✓	✓
Phil Jones	O	✓	O	O	✓	O
Hazel Kench	✓	✓	✓	O	O	✓
Dr Jon Kennedy		✓	✓	✓	✓	✓
Michelle Long	✓	✓	✓	O		
Mustak Mirza	✓	✓	✓	✓	✓	✓
Alan Rebeiro	O					
Sean Russell	✓	✓	✓	O	O	O
Maureen Smojkis	✓	✓	✓	O	✓	O
John Travers			✓	✓	✓	✓
Faheem Uddin	✓	✓	✓	✓	✓	✓
Non-Executive Director attendance						
Sue Davis	✓	✓	✓	✓	O	✓
Russell Beale	✓	✓	✓	✓	✓	✓
Barry Henley	✓	✓	✓	✓	✓	✓
Nerys Williams	O	O	✓	O		
Waheed Saleem	✓	✓	O	O	✓	✓
Joy Warmington	O	O	O	O	O	O
Gianjeet Hunjan	✓	✓	✓	✓	✓	✓
Linda Cullen					✓	O
Executive Director attendance						
John Short	✓	✓	✓	✓	✓	✓
Brendan Hayes	O	✓	✓	O	✓	✓
Sue Hartley	✓	✓	✓	✓	✓	✓
Hilary Grant	O	✓	✓	✓	✓	O
Charlotte Bailey	✓	✓	✓	✓	✓	O
Dave Tomlinson	✓	✓	✓	✓	✓	✓

O = did not attend ✓ = attended meeting

Key activity of governors in 2018/19

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.

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 carer and support groups
- participation in the Membership Engagement And Governor Involvement Strategy Refresh 2018 working group
- participation in regional and national governor conferences and events
- participation on recruitment panels including those for members of the Board
- taking part in the CQC Inspection Governor Panel
- involvement in the IHI quality improvement governor engagement sessions
- being involved in Dragons' Den panels

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 carer groups to support engagement with this cohort, which is another area of under-representation
- seminars on improving physical and mental health wellbeing; prison healthcare 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 the Membership Engagement and Governor Involvement Strategy Refresh 2018
- participation in the first annual membership survey
- attendance at a wide range of carers' events
- attendance at the Prison Healthcare Seminar on Treatment Behind Bars
- participation in the judging and ceremony for our Trust Quality and Excellence Awards for staff and other staff recognition events
- attendance at volunteers' tea party and volunteer recruitment events
- participation in workshops to develop our new Strategic Partnerships Strategy
- acting as judges on our Trust Dragons' Den innovation panels
- involvement in joint strategic sessions with the Board
- 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 and Black History Month
- 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 2019, our membership stood at 12,655 overall, comprising 6,484 members of the public, 1,413 service users and carers and 4,758 staff. This compares with an overall figure of 12,688 as at the end of March 2018. A cleanse of our membership database will be undertaken during 2018/19 to ensure it remains up to date.

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 2019

Gender	Public 2018	Public 2019	Service User/ Carer 2018	Service User/ Carer 2019
Unspecified	9	3	0	0
Male	57	47	12	6
Female	5,412	5,374	1,199	1,211
Transgender	1,079	1,060	204	196
Total	**6,557**	**6,484**	**1,415**	**1,413**

Public and patient membership gender profile at 31 March 2019

Gender	Public 2018	Public 2019	Service User/ Carer 2018	Service User/ Carer 2019
Unspecified	114	121	23	29
Male	2,352	2,306	510	500
Female	4,091	4,056	881	883
Transgender	0	1	1	1
Total	**6,557**	**6,484**	**1,415**	**1,413**

Public and patient membership ethnicity profile at 31 March 2019

Ethnicity	Public 2018	Public 2019	Service User/ Carer 2018	Service User/ Carer 2019
White	2,636	2,600	759	746
Mixed	181	180	47	46
Asian or Asian British	1,859	1,840	359	357
Black or Black British	770	766	175	181
Other	85	86	24	24
Not stated	1,026	1,012	52	59
Total	**6,557**	**6,484**	**1,415**	**1,413**

Public member constituency socio-economic groupings at 31 March 2019

Acorn Socio-Economic Category	Public 2018	Public 2019
AB	1,543	1,511
C1	1,773	1,745
C2	1,356	1,339
DE	1,754	1,731
Not known	20	21
Total	**6,446**	**6,347**

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, this work will continue in 2019/20 and will be expanded to include a focus on schools and colleges of further education. The Membership and Governor Engagement Strategy was refreshed in November 2018 and included 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 2018. 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; this has been started with a month long annual membership survey, which will help drive the focus for engagement for the upcoming year
- 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

The Trust's approach 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.

The Trust commissioned the Good Governance Institute to undertake an external well-led review, which was completed in October 2018. This, together with the quality improvement work commissioned from the IHI, will complement the Trust's work in making sure its services are well-led.

The CQC undertook a comprehensive inspection of the Trust in December 2018 and we received the results our CQC core service and well led inspection in March 2019. Our report confirmed a rating of Good for the domains of Caring and Responsiveness and a rating of Requires Improvement for Safety, Effectiveness and Well Led. This meant our overall rating was Requires Improvement. The CQC identified some positive improvements since their inspection in March 2017 and recognised that these improvements required further time to embed. The Trust is committed to improving its performance in core areas, particularly nurse staffing levels, supervision arrangements for staff, parts of our physical environment and our inclusion agenda.

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 are responsible for preparing 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 report on the use of Lay Managers within the Trust.
- The Committee agreed changes to the Executive Pay Framework.

During the year, the Trust implemented a new Executive pay framework, and assimilated all Executives (except the Medical Director) onto this framework.

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 include incremental progression 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.

Element	Purpose and link to strategic objectives	Operation
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 31 March 2019, salaries for non-executive directors were:

Chair	£47k
Vice Chair	£21k
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.

All Executive salaries are 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.

In February 2017 NHS England published 'Managing Conflicts of Interest in the NHS, Guidance for Staff and Organisations', which sets down guidance for all NHS organisations to follow as from 1 June 2017. The Declarations Policy was updated during the year to reflect this guidance.

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role.

Decision making staff in this organisation are:

- executive and non-executive directors
- those at Agenda for Change band 8c and above
- staff who have the power to enter into contracts on behalf of the Trust (Procurement Team)
- consultant medical staff.

The request for declarations went to all staff in January 2019, and declarations (including nil returns) are submitted electronically via the staff intranet. At the time of writing, 269 people who are classed as decision making staff were asked to provide declarations by 31 March 2019. Of these two have left the Trust, one has confirmed that they are on long term sick leave, 212 have provided declarations and 57 have provided no declaration at all despite repeated reminders and support offered. 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 2021 (originally a three year term, extended for two years)
	1 July 2013 (Associate Non-Executive Director) 1 August 2015 (Non-Executive Director)	1 August 2018 – 1 August 2021
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
Linda Cullen	1 December 2018	1 December 2018 – 1 December 2021

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 its 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 July 2018, the Committee discussed the outcome of the appraisal of Waheed Saleem, Barry Henley and Joy Warmington and were informed that they were performing well in their roles. The Committee agreed to reappoint Waheed for a term of three years and indicated their wish to extend the terms of Joy Warmington and Barry Henley. These were approved by the governors.

The Committee received and approved a pay proposal for non-executive directors for a pay uplift of two per cent for the Chair and non-executives. .

In November 2018, the Committee appointed Linda Cullen as a non-executive director from 1 December 2018 onwards. This appointment replaced Nerys Williams who came to the end of her term in November 2018.

Membership and attendance of Nominations and Remuneration Committee 2018/19

	12/07/2018	27/09/2018	22/01/2019
Faheem Uddin (Lead Governor)	✓	✓	✓
Maureen Johnson	O	✓	✓
Maureen Smojkis	✓	O	✓
Hazel Kench	✓	✓	O
Dr Jon Kennedy	-	✓	✓

O = apologies given ✓ = attended meeting P= partial

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

The gross pay in 2018/19 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 2018/19.

Remuneration Committee meetings, membership and attendance 2018/19

	30/05/2018	02/08/2018	22/08/2018	31/10/2018	20/02/2019
Sue Davis	✓	✓	✓	✓	✓
Nerys Williams	✓	✓	✓	O	-
Joy Warmington	✓	✓	✓	O	✓
Barry Henley	✓	✓	✓	✓	✓
Waheed Saleem	✓	✓	✓	✓	✓
Gianjeet Hunjan	✓	✓	✓	✓	✓
Russell Beale	O	✓	✓	✓	✓
Linda Cullen	-	-	-	-	✓

O = apologies given ✓ = attended meeting P= partial - = Not in post

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

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

Trust Board and governor expenses

Executive director expenses 2018/19

Executive Directors		Apr £	May £	Jun £	Jul £	Aug £	Sep £	Oct £	Nov £	Dec £	Jan £	Feb £	Mar £	Total £
Short	J	-	-	-	-	-	-	-	-	-	-	-	-	-
Fallon-Williams	R												-	-
Hayes	B	68	66	54	76	49	77	-	116	-	38	-	5	549
Bailey	C	147	64	29	83	20	-	72	145	134	16	23	88	821
Grant	H	72	72	72	72	72	72	72	72	72	72	72	72	859
Hartley	S	11	85	-	-	-	-	-	-	-	-	-	-	96
Tomlinson	D	28	22	31	46	31	30	36	58	44	10	57	-	393
Total		**325**	**309**	**186**	**277**	**173**	**178**	**180**	**391**	**250**	**135**	**151**	**165**	**2,719**

Non-executive director expenses 2018/19

Non-Executive Directors		Apr £	May £	Jun £	Jul £	Aug £	Sep £	Oct £	Nov £	Dec £	Jan £	Feb £	Mar £	Total £
Davis	S	-	-	-	-	-	-	-	-	-	-	-	-	-
Beale	R	-	-	2,167	-	-	-	185	-	-	-	-	-	2,352
Williams	N	46	69	-	-	-	196	52	57	26	-	-	-	446
Warmington	J	-	-	-	-	-	-	-	-	-	-	-	-	-
Henley	B	-	-	-	-	-	-	-	-	-	-	-	-	-
Saleem	W	-	-	-	-	-	238	-	-	-	-	-	-	238
Hunjan	G	-	-	-	-	-	-	-	-	-	-	-	-	-
Total		**46**	**69**	**2,167**	**-**	**-**	**434**	**238**	**57**	**26**	**-**	**-**	**-**	**3,037**

Governor expenses 2018/19

Governors		Apr £	May £	Jun £	Jul £	Aug £	Sep £	Oct £	Nov £	Dec £	Jan £	Feb £	Mar £	Total £
Chaudary	A	-	-	-	-	-	-	-	-	-	-	-	-	-
Uddin	F	-	-	-	-	-	-	-	-	-	-	-	56	56
Ali	K	-	-	-	-	-	-	-	-	-	-	-	-	-
Brookes	A	-	-	-	-	-	-	-	-	-	-	-	-	-
Long	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Jones	P	-	-	-	-	-	-	-	-	-	-	-	-	-
Johnson	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Smojkis	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Brown	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Russell	S	-	-	-	-	-	-	-	-	-	-	-	-	-
Kench	H	-	-	-	-	52	36	-	-	33	-	-	-	121
Dalziel	R	-	-	-	-	-	-	-	-	-	-	-	-	-
Mirza	M	-	-	-	-	-	33	-	-	-	-	-	55	88
Allen	N	-	-	-	-	-	-	-	-	-	-	-	-	-
Brown	P	-	-	-	-	-	-	-	-	-	-	-	-	-
Freshwater	E	-	-	-	-	-	-	75	-	-	-	-	-	75
Mustak	M	-	-	-	-	29	-	-	-	-	-	-	-	29
Ramsdale-Owen	J	-	-	-	-	-	-	-	-	-	-	-	-	-
Total		**-**	**-**	**-**	**-**	**82**	**69**	**75**	**-**	**33**	**-**	**-**	**111**	**370**

Governor Election Expenses were £3,920 during the year.

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.

Information subject to audit

Remuneration table

Salary and pension entitlements of senior managers – salaries and allowances

Name and Title	Year Ending 31 March 2019					Year ending 31 March 2018				
	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)	170-175	-	-	17.5-20	190-195	*165-170*	-	-	32.5-35	200-205
Roisin Fallon-Williams (Chief Executive Officer designate from 1 March 2019)	10-15	-	-	-	10-15					
Hilary Grant (Executive Medical Director - Appointed 1 April 2016)	100-105	55-60	-	62.5-65	220-225	95-100	55-60	-	62.5-65	220-225
Brendan Hayes (Chief Operating Officer/ Deputy CEO – Appointed 15 July 2013)	125-130	-	-	72.5-75	195-200	115-120	-	-	250-252.5	365-370
Susan Hartley (Executive Director of Nursing – Appointed 31 March 2014)	115-120	-	-	20-22.5	135-140	110-115	-	-	15-17.5	125-130
Dave Tomlinson (Executive Director of Finance – Appointed 1 April 2017)	120-125	-	-	-	120-125	115-120	-	-	-	115-120

Name and Title	Year Ending 31 March 2019					Year ending 31 March 2018				
	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
Charlotte Bailey (Executive Director of Strategic Partnerships – Appointed 1 August 2017)	110-115	-	-	25-27.5	135-140	70-75	-	-	15-17.5	90-95
Sue Davis (Chair – Appointed 28 November 2011)	45-50	-	-	-	45-50	45-50	-	-	-	45-50
Linda Cullen (Non-Executive Director) (Appointed 1 January 2019)	0-5	-	-	-	0-5					
Nerys Williams (Non-Executive Director – Appointed 1 December 2011)	10-15	-	-	-	10-15	15-20	-	-	-	15-20
Joy Warmington (Non-Executive Director – Appointed 3 January 2012)	20-25	-	-	-	20-25	20-25	-	-	-	20-25
Waheed Saleem (Non-Executive Director – Appointed 1 July 2013)	15-20	-	-	-	15-20	15-20	-	-	-	15-20
Dr Barry Henley (Non-Executive Director – Appointed 1 July 2013)	15-20	-	-	-	15-20	15-20	-	-	-	15-20

Name and Title	Year Ending 31 March 2019					Year ending 31 March 2018				
	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
Prof Russell Beale (Non-Executive Director) (Appointed 1 January 2017)	15-20	-	-	-	15-20	15-20	-	-	-	15-20
Gianjeet Hunjan (Non-Executive Director – Appointed 1 September 2015)	15-20	-	-	-	15-20	15-20	-	-	-	15-20
For both 2018/19 and 2017/18 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 (£58k during year ended 31 March 2018) for non-director responsibilities.										

Fair pay multiple

Fair pay multiple

	2018/19	2017/18
Band of Highest Paid Directors Total Remuneration (£'000)	170-175	165-170
Median Total Remuneration	29,197	28,043
Ratio	5.89	5.98

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 2018/19 was £170-175k (2017/18 was £165-170k) This was 5.89 times (2017/18 was 5.98 times) the median remuneration of the workforce, which was £29k (2017/18, £28k). In 2018/19, five employees received remuneration in excess of the highest paid director (in 2017/18 the figure was also five). Remuneration ranged from £170k to £175k (2017/18 £169k to £215k).

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 2018/19

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 2019	Lump Sum at Age 60 Related To Accrued Pension at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2019	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)(Resigned 31 March 2019)	0-2.5	5-7.5	65-70	205-210	1,401	1,624	181
Roisin Fallon-Williams (Chief Executive Officer designate)*	0	0	0	0	0	0	0
Charlotte Bailey (Executive Director of Strategic Partnerships)	0-2.5	0	0-5	0	13	37	24
Dave Tomlinson (Executive Director of Finance)*	0	0	0	0	0	0	0
Hilary Grant (Executive Medical Director)	2.5-5	10-12.5	60-65	180-185	1,175	1,411	201
Brendan Hayes (Chief Operating Officer / Deputy CEO)	2.5-5	10-12.5	50-55	155-160	904	1,122	191
Susan Hartley (Executive Director of Nursing)	0-2.5	2.5-5	40-45	130-135	812	963	127

* Roisin Fallon-Williams and Dave Tomlinson have opted out of the NHS pension scheme.

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

* Dave Tomlinson has opted out of the NHS pension scheme.

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:

Roisin Fallon-Williams, Chief Executive
Birmingham and Solihull Mental Health NHS Foundation Trust Date: 22 May 2019

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 2018/19 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 meeting in March 2017, the Trust Board 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 and c£6.7m in 2018/19; 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 2019/20 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 – information subject to audit

Analysis of staff costs

Staff costs	**Permanent £000**	**Other £000**	**2018/19 total £000**	**2017/18 total £000**
Salaries and wages	142,556	612	143,168	135,148
Social security costs	14,384	-	14,384	13,663
Apprenticeship levy	680	-	680	642
Employer's contributions to NHS pensions	16,490	-	16,490	15,783
Pension cost – other	-	-	-	-
Other post employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	302
Agency/contract staff	-	6,859	6,859	5,773
NHS charitable funds staff	-	-	-	-
Total gross staff costs	**174,110**	**7,471**	**181,581**	**171,311**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**174,110**	**7,471**	**181,581**	**171,311**
Of which Costs capitalised as part of assets	-	-	-	-

Average staff numbers – information subject to audit

Average number of employees (WTE basis)

	Permanent Number	Other Number	2018/19 Total Number	2017/18 Total Number
Medical and dental	128	95	223	221
Administration and estates	786	60	846	837
Healthcare assistants and other support staff	680	6	686	644
Nursing, midwifery and health visiting staff	1,160	38	1,198	1,186
Scientific, therapeutic and technical staff	537	85	622	603
Other	81	8	89	114
Total average numbers	**3,373**	**292**	**3,664**	**3,605**

Staff type by gender as at 31 March 2019

Staff type by gender at 31 March 2019

Staff Type	Female	% Female	Male	% Male	Grand Total
Directors	6	50	6	50	12
Other Senior Managers	176	61	112	39	288
Employees	2,627	72	1,022	28	3,649
Total	**2,809**	**71**	**1,140**	**29**	**3,949**

Sickness absence 2018/19

Sickness absence by month 2018/19

Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
4.56%	4.48%	4.59%	4.85%	4.87%	5.32%	5.06%	4.91%	5.28%	5.20%	4.48%	4.87%

Average sick days per WTE for calendar year January 2018 to December 2018

Average WTE 2018	Adjusted WTE days lost	Average sick days per WTE
3,684	42,388	11.5

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

The Trust aims to be an exemplar organisation which people want to access for care, recovery and employment. The Trust understands that diversity brings richness and innovation and welcomes applicants from the diverse population it serves.

The Trust has a number of specific policies and procedures such as the Equality, Inclusion and Human Rights Policy, Special and Carers Leave Policy, Flexible Working Policy, Dignity at Work Policy and Sickness Policy. The latter was recently reviewed to increase focus on wellbeing and include new Disability Leave Allowance alongside a portable reasonable adjustments passport to support staff affected by an underlying health condition. These polices are there in order to support our employees through their employment journey and make reasonable adjustments where possible enabling staff to feel valued and safe.
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.

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

On 7 March 2017, we were confirmed to be a disability confident employer by the government's Disability Confident Scheme. Being a 'disability confident employer' means that we have completed the disability confident self-assessment and are taking all of the 'core actions' to be a disability confident employer. These core actions include, for example:

- actively looking to attract and recruit disabled people
- providing a fully inclusive and accessible recruitment process
- ensuring employees have appropriate disability equality awareness
- promoting a culture of being disability confident.

We are now looking to become a ‘disability confident leader’, which means that we will have our self-assessment validated, and will demonstrate leadership in encouraging other employers to make the journey to become Disability Confident.

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.

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. Brendan Hayes, Chief Operating Officer and Deputy Chief Executive, was the executive sponsor for this network until his departure from the Trust in April 2019 and this role has now been taken on by Roisin Fallon-Williams, Chief Executive.

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. Sue Hartley, Executive Director of Nursing, is the executive sponsor for this network.

We made a huge improvement in our ranking in the Stonewall Workplace Equality Index 2019, leaping from 246th place out of 434 in 2018 to 135th out of 445 in this year's rankings, published today. The Stonewall Workplace Equality Index is now in its 15th year and represents organisations that are leading the way in making workplaces more LGBT inclusive and ensuring that LGBT employees, customers and service users can be safe, accepted and respected.

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

The Trust is dedicated to continued compliance with the Public Sector Equality Duty as set out in the Equality Act (2010) and the Equality and Human Rights Commission's Code of Practice. Additionally the policies above also enables the Trust to ensure commitment towards national standards such as for example the NHS Workforce Disability Equality Standard (WDES), Accessible Information Standard (AIS) as well as our commitment towards our Equality, Diversity and Inclusion Framework (2017-2020) which focuses on key actions arrived from the Equality Delivery System (EDS2) in order to address inequalities and overcome barriers.

Staff engagement

The Trust has a wide range of staff engagement activities, which are aimed at involving staff in the performance of the Trust. The Trust has three staff governors who sit on the Council of Governors from the constituency of medical, clinical non-medical and non-clinical staff. The Executive Team holds a number of 'Listen Up' events, where staff attend and can ask any question of a member of the Executive Team. Dragons' Den is an initiative which enables staff to 'pitch' for funding to support a local improvement initiative. In 2018/19 these mechanisms provided employees systematically with information of concern to them as employees and included:

- a weekly blog from the Chief Executive which updated staff on key developments and challenges facing the Trust, including financial and economic factors affecting the Trust's performance, and invited staff to feed back and engage with him directly
- a monthly Team Brief setting out matters of strategic importance which is cascaded from the Executive Team to every team at the Trust
- our 'Connected' monthly staff e-newsletter which looks at developments, achievements and development opportunities from a frontline perspective, by staff for staff
- a central news and information resource on our intranet, Connect, which 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
- the opportunity for teams 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
- 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
- Dear John, a stand-alone website that allows staff to raise their quality concerns, anonymously if they wish, direct with our Chief Executive
- Mental Health News, a round up of articles relating to mental health
- staff engagement meetings in service areas
- the Quality and Excellence Awards scheme, for which the fifth annual ceremony was held in November 2018. The cost of these awards is covered by sponsorship from carefully selected partner organisations.

Health and safety performance

In the last year, the focus of the work of the Health and Safety team has focused on the areas below:

- Significant changes and improvement to the management of fire safety in the organisation. The improvements include: a Trust wide approach to face to face fire safety training; regular fire drills with subsequent action plans for all sites; development of specific plans to ensure the implementation of actions from fire risk assessments; development of site specific procedures for all inpatient units as well as community buildings; work with procurement to standardise products to ensure compliance with fire safety standards.
- In response to concerns raised in the previous financial year around the availability of resources to ensure compliance with relevant fire safety legislation, it was agreed that an additional Health and Safety Advisor would be recruited to support with this work. The appointment has taken place and it means the Trust is in a position to take a far more proactive approach to health and safety activities.
- Collaborative work has taken place between health and safety, learning and development and human resources to develop a suite of training sessions to equip new managers with the right skills for their roles. There are four different health and safety sessions included in this.
- With the continued focus on improving patient safety during inpatient stays, the Estates Team and members of the Health and Safety Team worked with suppliers to develop an anti-ligature door set. This product has been trialled on the female PICU and will be evaluated in the coming months for its effectiveness and possible use on a larger scale. Another product will also be trialled on another unit to ensure the best product is rolled out as required.
- More fire incidents and RIDDOR incidents have been investigated by the team this year, with recommendations leading to changes in practise and the environment as appropriate.
- The new Searching of Service Users in Inpatient Settings and Security Management policies were implemented in the last year and although there has been some learning from these, they have largely improved staff and service user safety.

Other key points to note are:

- All environmental and ligature risk assessments for the Trust are in date, with all units' assessments now accessible on our intranet. The health and safety section on the intranet has been revamped and made more user friendly for staff.
- The Trust received no enforcement notices and had no Never Events in 2018/19. This was also the case in 2017/18.
- All Central Alerting System (CAS) alerts were responded to within the given timeframe.
- In 2018/19 there were 19,329 reported untoward incidents (an increase on 2017/18 by 3,079 incidents) – this shows an improvement in the reporting culture.
- Incidents of violence and aggression on inpatient units accounted for 4,408 in 2018/19 (compared to 3,507 in 2017/18). Of this figure 1,057 were as a result of physical assaults on staff compared to 940 in 2017/18.

- The number of false fire alarms reported in 2018/19 was 78, a decrease of one on the 2017/18, when there were 79.
- The number of actual fires reported in 2018/19 was 14, the same figure as the previous year. Of these three were accidental, five were wilful/arson and six undetermined.
- There were 54 staff and 525 service user slips, trips and falls incidents in 2018/19. This compares to 78 staff and 536 service user incidents in 2017/18, a decrease of 31 per cent for staff and a decrease of two per cent for service users.
- Personal accidents to staff (excluding slips, trips and falls) accounted for 187 reported incidents which is a decrease of 38 on 2017/18 figures.

A total of 57 incidents were reported to the Health and Safety Executive (HSE) under the requirements of RIDDOR in 2018/19.

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 achieved the following:

- 110 health promotion sessions across 19 locations
- 1,015 staff engaged in the programme, plus 622 staff attended drop in sessions or 1:1 health sessions.
- 30 general health promotion sessions
- 63 know your number (KYN) sessions
- 9 resilience and mindfulness sessions
- 11 open drop in sessions covering better backs, sleep, heart health and weight management
- 35 musculoskeletal workshops
- 22 mental health workshops
- 1 women’s health workshop.

Staff also have access to the PAM Life app and website which was launched in November 2018. 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, 148 staff have registered on PAM Life since its launch in November 2018.

Within PAM Life 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
- access to PAM Life coaches to provide 1-1 help for staff to improve fitness, nutrition, lifestyle and general health.
- live chat
- access the Health Genie Kiosk – giving staff a full health assessment including blood pressure, BMI, giving a full health summary and wellness goals, which syncs into their PAM Life account
- join clubs – including weight management and walking clubs amongst others
- access healthy recipes
- find access to many health resources, including videos, articles and fitness programmes
- access resources that 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

A total of 1,503 staff completed the survey which gives us an overall response rate of 40 per cent (average response rate for similar trusts was 51 per cent). This is a decrease of four percentage points since the previous year for which the response rate was 44 per cent.

From 2018 onwards, the results from questions are grouped to give scores in ten indicators. Scores for each indicator together with that of the survey national average for mental health are presented in the following table:

Staff survey summary of performance

	2018/19		2017/18		2016/17	
	BSMHFT	**National Average for Mental Health**	**BSMHFT**	**National Average for Mental Health**	**BSMHFT**	**National Average for Mental Health**
Equality, diversity and inclusion	8.4	8.8	8.3	9.0	8.5	9.0
Health and Wellbeing	5.7	6.1	5.7	6.2	5.8	6.2
Immediate Managers	7.1	7.2	6.9	7.2	7.0	7.1
Morale	6.0	6.2	-	-	-	-
Quality of Appraisals	5.4	5.7	5.2	5.5	5.3	5.5
Quality of care	7.2	7.3	7.3	7.3	7.5	7.4
Safe environment – bullying and harassment	7.5	7.9	7.4	8.0	7.7	8.0
Safe environment – violence	9.1	9.3	9.0	9.2	9.1	9.2
Safety culture	6.4	6.7	6.4	6.7	6.5	6.6
Staff engagement	6.8	7.0	6.7	7.0	6.8	6.9

Areas of improvement / deterioration from prior year

The survey is a key part of the way we listen to our staff views so that we can make our Trust a better place to work. There are 10 broad themes within the survey, of which there has been improvement in the following key areas:

- immediate managers
- quality of appraisals
- staff engagement.

There has, however, been no significant change in scores in relation to the other areas. While overall the results show a better picture compared to last year's results some of the survey results are very disappointing, particularly that we have poor scores for bullying and harassment and we still have significant work to do on equality, diversity, inclusion and quality of care.

In responding to that feedback from the 2017 survey results we identified four key areas of focus for improvement as follows:

Supporting staff health and wellbeing

Over the last 12 months we have undertaken dedicated work to improve the health and wellbeing of staff with health promotion sessions and workshops across various Trust sites. Furthermore to strengthen these initiatives further we undertook a health and wellbeing audit for each service, meeting with staff and analysing key areas of improvement which resulted in more targeted support based on staff feedback, for example physiotherapy drop in sessions were introduced at various sites. Additionally, in conjunction with service areas, we developed plans to continue to focus on key areas such as stress at work and musculoskeletal issues.

We have also launched an online health promotion platform - PAM Life - which provides staff with a better way of tracking their health and accessing health, nutritional and lifestyle advice, videos and resources. Separately we rolled out the 'supporting you to be healthy and happy at work' staff support campaign which included: promotion of support available through news items, leaflets, posters and a payslip attachment. Roadshows took place across 15 locations and over 200 staff attended these events. We introduced the first event BSMHFT Staff Family Cookbook with recipes submitted by our own staff to share with each other to promote how food can boost mood and improve mental and physical wellbeing. We also relaunched our extended staff benefits offer as part of the review of our current reward and recognition offer

Team effectiveness

We implemented an innovative and evidence based approach around team effectiveness (in conjunction with Aston OD) with 10 Team Coaches trained and over 70 teams having participated in the programme.

There has been significant improvement shown in the staff survey relating to team effectiveness, with some questions improving by over 3 per cent since 2017, showing an over 5 per cent improvement since 2016.

Inclusion and dignity at work

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

Additionally, we also completed a review of the revised Sickness Absence Policy to increase focus on wellbeing and include new Disability Leave Allowance combined with a portable reasonable adjustments passport to support staff affected by an underlying health condition

In the pipeline are a new Behavioural Competency Framework for all staff, a new Performance Policy and the creation of the role of Inclusion Advisors within the Trust.

We have also undertaken significant work around the review and relaunch of staff networks, and various other initiatives as part of EDS2 and 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, reduce bullying and harassment and promote equality in the workplace.

Safety at work

We established the Compassion at Work Group, chaired by the Executive Medical Director. The purpose of this group is to bring together clinicians and non-clinical teams across the organisation to work together to deliver a framework in enabling a culture of compassionate care across the organisation. Through this group we have implemented targeted support for staff experiencing violence and trauma at work (including support at coroner's inquests, giving evidence at court, legal and HR processes). Additionally, we have also implemented Schwartz rounds which are a multidisciplinary forum designed for staff to come together to discuss and reflect on the non-clinical aspects of caring for patients as well as Balint Groups to ensure support is available to a professional affected by suicide in the few weeks after the event.

Future priorities and targets

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 internal engagement work such as Listen Up conversations. This will help us to develop a renewed set of actions based on staff feedback and involvement.

We aim to build on existing activity outlined earlier including 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.

We will agree a clear Trust wide action plan which will be monitored through the Trust Workforce Sub-committee and reported to the Board periodically.

Trade union facility time disclosures

Relevant Union Officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
11	4.0 wte

Percentage of time spent on facility time

Percentage of time	Number of Employees
0%	0
1-50%	7
51-99%	4
100%	0

Percentage of pay bill spent on facility time

Provide the total cost of facility time	£90,000
Provide the total pay bill	£143,167,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.06%

Expenditure on consultancy

Expenditure on consultancy in 2018/19 was £637k, compared to £263k in 2017/18.

High paid off-payroll engagements

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months

Number of existing arrangements as of 31 March 2019	0
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	0
Number that have existed between two and three years at time of reporting	0
Number that have existed between three and four years at time of reporting	0
Number that have existed for more than four years at time of reporting	0
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 2018 and 31 March 2019, 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 2018 and 31 March 2019	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:	
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 2018 and 31 March 2019

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 – information subject to audit

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 2017/18. 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 2017/18.

Staff exit packages 2018/19

Exit package cost band	Number of compulsory redundancies 2018/19	Number of other agreed departures 2018/19	Total number of exit packages by cost band 2018/19	Total number of exit packages by cost band 2017/18
<£10,000	-	-		4
£10,000 - £25,000	-	-	-	2
£25,001 - £50,000	1	-	1	4
£50,001 - £100,000	1	-	1	4
£100,001 - £150,000	-	-	-	-
£150,001 – £200,000	-	-	-	-
Total number of exit packages by type	2	-	2	14
Total resource cost £'000			113	450

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

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.

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 placed the Trust under "targeted support" i.e. support needs identified in Quality of care.

This segmentation information is the Trust's position as at 30 April 2019. 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	2018/19 scores				2017/18 scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	3	4	4	4	3	4	4	4
	Liquidity	2	2	2	2	2	2	2	2
Financial efficiency	I&E margin	1	2	2	2	1	2	3	2
Financial controls	Distance from financial plan	1	1	1	1	1	1	1	1
	Agency spend	1	2	2	1	1	1	1	1
Overall scoring		2	3	3	3	2	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
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy 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:

Roisin Fallon-Williams, Chief Executive
Birmingham and Solihull Mental Health NHS Foundation Trust 22 May 2019

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 2019 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.

The **Director of Nursing** (on behalf of the Chief Executive) is the executive director responsible for coordinating 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, performance review, 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 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 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 (IGSG) with the **Medical Director**, who is the Caldicott Guardian. IGSC reports to IQC.

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 and sustainability.

The **Company Secretary** has overall responsibility for the reporting to the 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. 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 and critically reviewed.

There has been a wide-ranging review of the Trust's approach to strategic risks and steps taken to ensure that the BAF more accurately reflected these. The strategic risks were revised and consolidated in September 2018 to provide an overall picture of the strategic risks affecting the Trust. The Trust received reasonable assurance from 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 areas of responsibility.

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
- endorsing 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 Board via the BAF.

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 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/Trust wide 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 the Trust Board and their responsibilities are set as follows.

Audit Committee

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

- governance, risk management and internal control
- internal audit
- external audit
- other assurance functions
- the soundness of the risk management process.

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 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 the 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 of 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
- oversee approach to investment ensuring the investment policy is implemented effectively
- ensure appropriate systems of control over charitable fund 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.

Well Led Framework

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 The Board commissioned an external well-led review, the findings of which it received in October 2018. This, together with the quality improvement work commissioned from IHI and the CQC's inspection of services in December 2018, will form the basis of future work against the well led framework.

The principle of learning lessons remains a priority. The Trust continues to receive assurance by receiving an integrated quality report on a quarterly basis at the 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.

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.

All performance information in relation to the Trust's priority indicators are reported to the Finance, Performance and Productivity Committee. Each report includes a RAG rating 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 staff empowerment. 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 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, the Director of Nursing and the Associate Director of Governance. Our internal approach to peer review against the regulatory framework 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. The approach is now under further development. 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 Trust wide approach to quality improvement (QI). We have entered into partnership with the IHI to assist us in this journey and have completed a full diagnostic and future plan for improvement which is now being deployed. During the year work has taken place with the Board and senior leaders to explore culture and psychological safety. We are now moving forward to develop internal capacity and capability in quality improvement through large scale training for front line staff and the establishment of a centralised expert QI team.

We have continued to focus on learning from good practice during the year and have implemented Learning from Excellence, received training in appreciative inquiry, training in human factors and have adopted safety initiatives such as the 'kitchen table' approach.

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

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. During the year we have established a Compassion at Work Group to ensure that support is available to staff undergoing challenging times and have now started our first Schwartz Rounds and Balint Groups.

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 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 have occurred investigations are carried out, lessons learnt and recommendations made and implemented where appropriate.

Workforce risks: The Trust has established a Workforce Committee which monitors progress against the People Strategy and People Plan approved by the Trust Board. It also reviews workforce systems and reporting and performance against key metrics, including safe staffing. The Workforce Committee reports to the Integrated Quality Committee.

NHS Improvement's 'Developing Workforce Safeguards' provides a comprehensive set of guidelines on workforce planning. The Trust maintains an ongoing review of all relevant guidance and takes steps to remain compliant.

The Board and Committees have had several informal discussions about risk appetite and are fully aware of the benefits of this, but have not yet formalised a position in this regard.

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 services to miss savings targets and scale of financial pressures relating to underfunding.
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 patients across all services and particularly in 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 specific risk of staff exposure to the use of legal highs within the prison remains however the risk is presently reduced due to the increased number of prison staff within the prison since the contract was taken back from G4S.
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. There is an expectation that this risk will reduce with an upgrade to the EPMA system in early 2019.
Waiting times	Risk of inability to monitor waiting time levels due to lack of monitoring system. Risk of waiting lists 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 2018/19.

Actions to address:

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 Board. 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 Annual 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 clinical quality and 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 clinical quality and equality impact assessment. These are required to be approved by the relevant Clinical Director and escalated to the Director of Nursing and Medical Director as appropriate, 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 (for example, 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 the key to our success. The Trust delivers against 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 in March 2019 following the Chief Inspector of Hospitals inspection in December 2018. At the time of writing this statement, five of the Trust's nine core services have a rating of 'Good'.

The Trust has received 10 inspections during 2018/19 in relation to Mental Health Act compliance. The learning from MHA inspections helps the Trust to continually improve its services. The top four themes raised were:

- patient involvement in care plans / inclusion of discharge planning
- location of payphones and privacy
- quality of capacity assessment
- understanding rights.

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 published an up-to-date register of interests for decision making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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

The Trust has undertaken risk assessment and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. 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 multi-disciplinary group (with external specialist advisors) to compile the sustainable development management plan, detailing 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 strengthened in 2018 from the improvements made in the previous year 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. The Trust is committed to improving its inclusion agenda in 2019/20

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

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

For 2018/19, we ended the year with a Single Oversight Framework segment of 2. This is NHS Improvement's framework for overseeing providers and identifying potential support needs. We achieved this rating in a year where the cash releasing efficiency savings were set at a particularly challenging level.

We were still able to invest significantly 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 2018/19, 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 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. 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.

TIAA carried out 14 reviews for 2018/19 (seven Assurance reviews, three Compliance reviews and four Appraisal reviews). The seven 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 which 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 objectives.

The seven Assurance reviews are finalised and have been issued with 'reasonable assurance', three Compliance reviews, of which two are at draft report stage have been issued with 'limited assurance'. The remaining four reports were appraisal reports without an overall assurance opinion and have been finalised.

There were three areas 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 the Locality Compliance Review, Conflicts of Interest Review and Compliance Review of Data Quality – Return to Work KPI. The limited assurance opinions were based on the following key findings at the time of the audit fieldwork:

Locality Compliance Review

- Two areas were not providing the feedback on central alerts, a further three had missed a Trust response deadline and there is opportunity to develop processes further.
- Two of 11 areas were not consistently completing the daily Immediate Life Support checklist, including not applicable points or Managers checklist.
- Petty cash arrangements require tightening (security of a ward held petty cash, key safekeeping, sub-float and records/ receipts to support balances in full and ensuring expenditure aligns with fund purposes).
- Controls have been established over the entry to sites, security checks, staff challenge and request for visitors sign in and identity badges and the issuance of attack alarms; however these require more consistent application.
- PAT testing and equipment servicing was not consistently evidenced for the items reviewed at eight of the 11 locations visited.

Conflicts of Interest Review (Draft)

- In respect of decision making staff that have not submitted declarations, the enhanced escalation procedures be incorporated in the Policy and monitored.
- Trust to investigate potential breaches for staff that have not submitted declarations of interest.
- The revised Policy be made available on the Trust website and reflective of the Data Protection Act 2018 incorporating GDPR requirements.

Data Quality – Return to Work (RTW) KPI (Draft)

- Areas of non-compliance with the Trust policy Supporting and Managing Workforce Sickness Absence were identified which require improvements to be made.
- Self-certificates were not available at three of four departments visited, and where these were seen completion was inconsistent.
- Similarly, return to work interviews were not being undertaken and 14 of the episodes tested were either not appropriately recorded on Trust systems or supported by a completed and signed return to work interview form which was held on file, four were not completed on a timely basis.
- In addition, approval to finalise monthly roster data and the input of RTW details for areas reported as achieving 0% RTW compliance was found to be untimely.

Information Governance

In 2018/19, the Trust did not report any incidents to the Information Commissioner's Office (ICO) and the one outstanding case from 2017/18 was closed by the ICO with no action taken against the Trust.

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 (IGSG) chaired by the Caldicott Guardian or Senior Information Risk Owner (SIRO).
There has been continued progress in the comprehensiveness, rigour and quality of the Trust's IG arrangements during 2018/19.

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 reported to and reviewed by both IQC and the Board throughout the year.

There have been improvements in the majority of our quality goals when compared to the 2017/18 outturn position. We are however facing challenges in achieving the overall target levels set at the start of the year in some indicators including falls within the Dementia and Frailty Services and clinical risk management. The quality goals for 2018/19 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 clinical risk management, the provision of physical activities for patients and compassion in the working environment. We know that compassion shown by staff can make all the difference to a patient's experience of care.

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:

- First episode psychosis services - 53 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 2019, we achieved 98.7 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 2019, we exceeded both targets with 96.8 per cent of service users beginning treatment within six weeks 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 2019, 100 per cent of urgent cases were seen within one week and 100 per cent of routine cases were seen within four weeks.

We have met the quarterly IAPT Moving to Recovery target of 50 per cent.

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, the Finance, Planning and Performance Committee and Integrated Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Audit Committee has an annual programme of work related to identify 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 regulatory 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 critical review by the Audit Committee.

Conclusion

No significant internal control issues have been identified and the Trust believes that by addressing its key risks and issues it has a system of internal control that supports the achievement of the organisation's plans, aims and objectives.

Signed:

Roisin Fallon-Williams, Chief Executive
Birmingham and Solihull Mental Health NHS Foundation Trust Date: 22 May 2019

Quality Report

Section one

Statement on quality from the Chief Executive

I am delighted to present our Quality Account for 2018/19. I am grateful to our c4,000 strong workforce who day in day out, provide ongoing care for our patients and support to families, carers and each other as staff. Sometimes the environments that we work within can be complex and challenging and we are proud of all of our staff for the valuable work that they do particularly against another challenging year across health and social care systems where pressures and demands for mental health services have increased once again.

This account details the progress that we have made in delivering the first two years of our three year Quality Strategy 2017-2020. As we near the end of our second year of our strategy, it is an opportunity to reflect on the progress that we have made and also the challenges we have encountered.

We have a positive story of improvement, albeit there are also challenges which we must overcome. Our Quality Strategy, which was approved by the Board in March 2017, detailed the following quality ambitions:

Safety – Preventing suicides, deaths in care and reducing harm
Safety – Embed a culture of least restrictive practice with reduced incidents of restraint, seclusion and physical assault
Safety – Ensure that robust and dynamic clinical risk management is embedded in day to day practice to support the safety and recovery of our patients
Effectiveness – Ensure that all patients receive care that is predicated on evidence based guidance from NICE
Effectiveness – Promote recovery, good mental and physical health
Responsiveness – Ensure that people have a positive experience of care by listening to service users, families, carers, staff and stakeholders to continuously learn and improve our quality of care
Caring – Ensure that patients, carers and families are able to contribute to developments aimed to enhance the patient experience
Well Led – Ensure that quality governance is strong and consistent across services

We have made good progress in delivering our goals linked to suicide prevention and our national benchmarking position has improved as per the National Confidential Inquiry from 9.2 suicides per 100,000 population in the first year of our strategy to 8.0 suicides per 100,000 population in the second year of our strategy. Birmingham and Solihull has the eighth lowest suicide rate in England at the time of writing this report.

Our journey of least restrictive practice continues and we now have Safewards in place across all of our inpatient units. Our levels of prone restraint have reduced by 14 per cent compared to 2017. At the start of this strategy National Health Service Improvement (NHSI) benchmarking showed that the Trust had some of the highest levels of restraint in the country.

Two years into our strategy, and with the expert guidance and support of our Positive and Proactive Care Expert Panel, we have moved out of the upper quartile for these incidents, and in some areas such as older people's services are now below the median line. Levels of violence have also reduced during this period, and we have also developed our relationship with Operation Stonethwaite. Our Positive and Proactive Care Expert Panel has undertaken much work to understand the experience of seclusion within the Trust and has engaged the views of patients and staff to help identify improvements that we can make to the seclusion experience.

Our approach to physical health has also improved in some areas. We know from national mortality research that the life expectancy of those with a serious mental illness can reduce by approximately 15 per cent due to lifestyle choices. Over the last two years, we have increased our recording of cardio metabolic indicators such as blood glucose levels, alcohol use, tobacco use and BMI from 38 per cent to 60 per cent of inpatients and in our community services from 6 per cent to 28 per cent. Understanding these indicators means that we are able to help provide advice and support to patients under our care in relation to diabetes, smoking cessation, alcohol and drug misuse and weight loss. One of our commitments in our strategy was to 'provide an enhanced range of physical health opportunities and activities for patients in our inpatient services'. During the two years we have funded outdoor gyms in a number of our inpatient units and, for example at Hillis Lodge, all patients are encouraged to use a pedometer to measure the steps that they are taking daily. Activities more generally across the Trust do however need to increase. We know this from the feedback from our inpatient survey in 2018/19 and from Friends and Family feedback. Our quality improvement projects will include activity related projects during 2019/20. In our Dementia and Frailty Services we continue to see challenges associated patients falling whilst under our care. We have not achieved our goal of reducing falls. Much work is taking place in this area and this will form a strong focus for our Quality Improvement Programme in 2019/20.

Our journey of recovery has moved at a great pace with the commitment and involvement of staff, patients, families, carers, governors and experts by experience. During the first two years of our strategy we have extended the Recovery College model to Solihull and to the north of Birmingham. 'Recovery for All' training now features on our mandatory training programme with good participation levels. The Recovery College has achieved IMROC accreditation and our co-production agenda is developing positively. We have established a Family and Carer Pathway Group which has overseen a number of positive developments including the carer assessment tool, wording to be included in our complaint letters and serious incident investigation letters to families, and the development of our Carers Strategy. Our strategy set out an aim for us to achieve a score of 90 per cent from the Friends and Family Test for patients recommending our Trust as a place to receive care. Our score is published monthly on the NHS England website and the latest publication (January 2019) demonstrated that we had achieved this goal at that stage. Acting on feedback from the Friends and Family Test and learning from incidents, complaints and audit has been a real focus for us during the first two years of our strategy. We have developed new approaches such as the 'Kitchen Table' safety approach, adopted 'Learning from Excellence', established our video library of 'It Takes Three' videos (three key lessons in three minutes) and developed our integrated learning lessons bulletin to all staff. We have also seen improvements in our Community Mental Health Survey scores with 'significantly higher' results this year for two questions.

- Did you feel that decisions were made together by you and the person you saw during this discussion?
- Do you know who to contact out of office hours if you have a crisis?

Our Trust's results were significantly lower this year for no questions.

Clinical risk management has seen some improvement. This continues however to be an area of challenge for us. When things go wrong in the Trust, issues pertaining to clinical risk management are often contributory factors. Latest training figures show that staff are struggling to leave their workplace to attend training and we are not attaining our training level at the time of writing this report. Work is taking place to understand whether the training can be incorporated into our suicide prevention training as there are currently some areas of duplication. This will provide a more cohesive package of learning for our colleagues and reduce 'the number of courses' that they need to attend, enabling increased direct time to care.

Since March 2017, we have taken forward a number of initiatives to help us better understand the experiences and outcomes for our patients at an organisational level. These include the development of an integrated dashboard pulling together quality, workforce, sustainability and performance. As mentioned above, our lessons learnt framework has significantly developed albeit more work is always required in this important area. We have appointed the Institute for Healthcare Improvement as our expert partner in quality improvement (QI) and are now at a very exciting point of our QI journey whereby staff are showing great enthusiasm and have opportunities for expert QI training to help them deliver better care and have a better staff experience too. Working alongside our HR colleagues, we have established a Compassion at Work Group and have commenced Schwartz rounds and Balint Groups to provide staff with support at challenges times. Schwartz Rounds are a multidisciplinary forum bringing staff together to reflect on the emotional challenges associated with their jobs. The focus is not on the clinical aspects of the patient, but on staff experience. We know that the compassion shown by staff can make all the difference to a patient's experience of care and that staff must therefore, in turn, feel supported in their work.

Amidst all of this activity, we were inspected by the Care Quality Commission (CQC). We have received our CQC core service and well led inspection which was reported on at the end of March 2019. Our report confirmed a rating of Good for the domains of Caring and Responsiveness and a rating of Requires Improvement for Safety, Effectiveness and Well Led. This meant that our overall rating as a Trust was Requires Improvement. Whilst we continue on our journey towards Good, we should recognise some of the great comments and outstanding aspects of care that were cited by the CQC in their report. These include:

- 'Staff treated patients with compassion and kindness. Staff were caring and passionate about their roles'.
- The Trust had improved collective leadership and the board and senior leaders were confident about plans to improve the quality of care. The Trust was working with a number of organisations and stakeholders to improve services. They had learnt from other organisations to develop a culture of quality improvement and we saw signs of achievement.

- The ‘See Me’ user involvement project promoted patient involvement in planning and delivering mental health services across Birmingham and Solihull. The Trust customer relations team assisted patients and carers to stay actively involved with the Trust.
- Hillis Lodge had developed a range of outstanding practice related to healthy lifestyles and patient engagement. New outdoor exercise equipment had been installed in the communal garden area and there had been a very high uptake from patients at sessions using these. Pedometers had been purchased and patients were encouraged to wear these out when going into the community. Information about steps taken communally was then being used to create events and sessions for patients.

It is clear however from the CQC report that we need to make improvements in some core areas – particularly nurse staffing levels, supervision arrangements for staff, and some physical environmental improvements. We also need to make strides forward in ensuring that equality and diversity is embraced across all areas of the Trust and champion our staff network groups to have a strong voice that is heard in all aspects of our business.

A further area to highlight in this introduction is the team at our Health Exchange. This service is supplementary to the core services already provided by the Trust across other aspects of mental health care. The team provides mental, physical and primary care support to the homeless and during the year has worked really hard to address concerns raised by the CQC about compliance with regulations. We are waiting for a formal report to confirm whether the progress and hard work seen in the last six months has moved the service out of an inadequate CQC rating. Verbal feedback has been really positive from the CQC and so we hope that the formal report recognises equally the improvements seen by the CQC in a recent inspection 1 April 2019.

As I close this introduction, I reiterate my thanks and that of the Board of Directors to our committed staff, our service users, families and carers, our stakeholders and our Council of Governors and look forward to making even more progress in 2019/20. I also want to take the opportunity to express our heartfelt thanks to our recently retired Chief Executive, John Short, who left the Trust at the end of March 2019 and to extend our best wishes to him as he enters retirement.

Thank you 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.

Signed:

Roisin Fallon-Williams, Chief Executive
Birmingham and Solihull Mental Health NHS Foundation Trust Date: 22 May 2019

Section Two

This section contains:

Priorities for improvement during 2018/19

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.

Well Led

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

Why is this important?

The Care Quality Commission (CQC) awarded a rating of Requires Improvement to the Trust for the domain of well led during its 2018 inspection. The CQC recognised within its report that there is a strong link between the quality of overall management of a Trust and the quality of its services. The importance of the development of a culture of quality improvement was noted. 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.

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.

Did we achieve the goal?

In terms of the measures of success associated with the early establishment of quality improvement within this goal, it has been fully achieved over the last financial year. The CQC noted in its 2018 report that the Trust has learnt from other organisations to develop a culture of quality improvement and that they saw signs of achievement. Activities have included the appointment of the Institute for Healthcare Improvement (IHI) as the Trust partner for quality improvement (QI) in 2018. The Trust is currently in the process of recruiting quality improvement advisors to enable it to start developing the internal infrastructure for quality improvement. In terms of developing skills and capacity, IHI has had a number of sessions with staff at different levels in the Trust to improve their QI skills. These included sessions with the Board, stakeholder groups and senior managers. There was a two day leadership workshop with senior managers in the Trust in February to review the culture of the organisation and what this should look like going forward. To enable feedback from a wider cross section of the organisation, a crowd sourcing event will take place to allow all staff to give their views on this area.

Ensuring we have the skills we need to develop continuous quality improvement

It is important that we have the skills in place to enable continuous quality improvement both centrally and at the frontline of service delivery. Executive leadership of the QI agenda is delivered by the Director of Nursing and the Medical Director, ensuring that clinical drive, effectiveness and leadership is at the forefront of the partnership. Central support for quality improvement is governed through the portfolio of the Associate Director of Governance who oversees the establishment of a central team of improvement advisors who work closely with teams across the Trust. Training for improvement advisors is delivered by IHI and this focuses heavily on system thinking, understanding variation, and the integration of a set of improvement methodologies known as the Model for Improvement. As such the Associate Director for Governance has completed Chief Quality Officer training, the Medical Director has completed Patient Safety Executive training and one of the improvement advisors has now commenced his Improvement Advisor training.

Strong clinical involvement and leadership will be critical to success and training will be available for 40 participants to be trained as improvement coaches. Hundreds of our staff will be trained in more basic QI tools that they can utilise with immediate effect in their local workplaces based on the science of improvement. Staff from across the Trust have identified our first 60 improvement projects to take forward in 2019/20 – all of which focus on improving care and experience for patients and staff.

In addition, we had 500 licences available to staff for access to the IHI Open School since 1 September 2018. This enables our staff to have 24/7 access to some excellent online training tools in quality improvement and access to a wide range of resources to help them to plan better care. During 2019/20 we will also provide training to experts by experience to ensure that co-design and co-production are fundamentals within our approach to improving quality.

This solid infrastructure will provide the foundation required to get QI established as business as usual for the Trust and assist it in delivering its ambitions.

Safe

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.

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 and team level.

Measures of success

- Reduce falls across our inpatient services by 15 per cent compared to the 16/17 out-turn.
- To reduce falls that result in significant harm by 50 per cent compared to 17/18.
- Increase cardio metabolic assessment of inpatients and community patients with a diagnosis of psychoses to achieve 90 per cent of inpatients and early intervention (EI) patients and 75 per cent for community patients on 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.

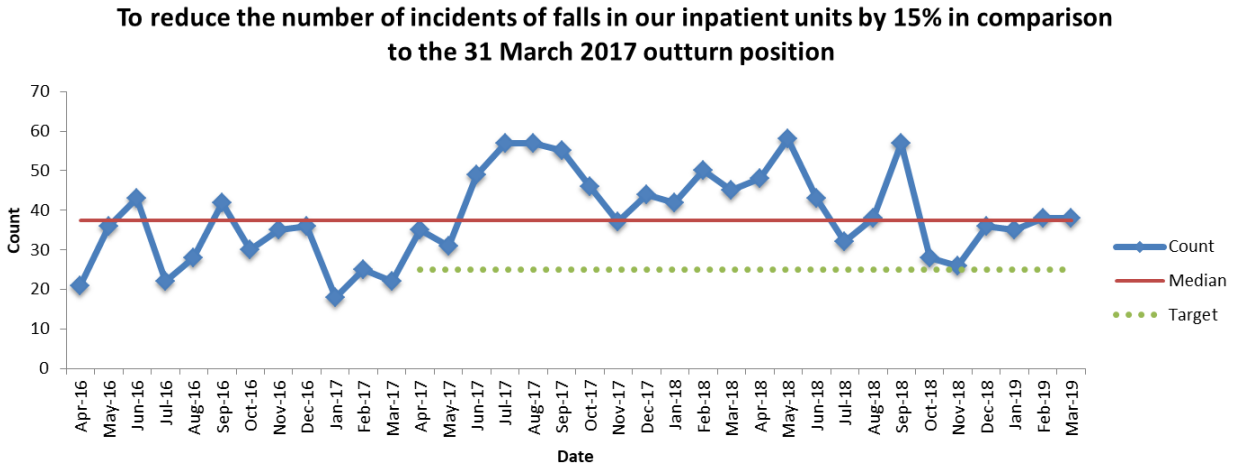
Targets

Goal	2016/17	2017/18	Target for 2018/19
Reduce the incidents of falls on inpatient units by 15% compared to 16/17	358	547	Target - 304 actual 477
Reduce the Falls that result in significant harm by 50% compared to 17/18	5	2	Target - 1 actual 7
Increase cardio metabolic assessment of inpatients and community patients with a diagnosis of psychoses to achieve 90% of all inpatients and all EI patients and 75% for community patients on CPA with a diagnosis of psychosis	N/A	Inpatient = 61.5% Community = 27.5%	Inpatient and EI = 90%, actual 26.9% for EI and 63.5% for Inpatient Community = 75%, actual 25.5%

Did we achieve the goal?

While there have been a number of positive steps to improve physical health in the reporting period, the quantitative targets set out have not been met. However the following has been achieved and work will continue in 2019/20 to improve overall patient experience and quality of care.

Number of falls on inpatient units



Falls Resulting in Serious Harm

2016 /17	2017 /18	2018 /19	Apr 18	May 18	Jun 18	July 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
5	**2**	7	1	0	3	0	0	0	0	0	2	1	0	0

In recent years the Trust has endeavoured to reduce the number of falls within the organisation and has developed numerous strategies and approaches to enable the delivery of this. Whilst we have seen some variation in our numbers, these have been random suggesting that we need further new interventions to make sustainable improvement in this important area of care.

The Trust asserts that all patients will have a falls risk assessment on admission if they are considered at risk and a multi-factorial assessment is completed if this is highlighted, Occupational therapy (OT) and physio review if appropriate, a multi-disciplinary team (MDT) falls huddle is conducted if they experience a fall, patients are offered anti-slip socks and medication is reviewed to reduce polypharmacy where possible. We maintain an oversight on national best practice, the falls strategy group meets monthly to review progress and we have recruited falls champions.

Despite these consistent efforts, a significant impact on the reduction in the actual number of falls has not been achieved. Going forward, instead of a focus purely on quantitative measures that do not necessarily impact on patient outcomes, we will put in place qualitative methods of improving patients' experience around falling. An example of this might be recognising that when patients have been affected by a fall they are likely to experience a significant fear of subsequent falls. This may leave patients reluctant to mobilise which can lead to de-conditioning, incontinence, risk of pressure damage, systemic infection and ironically a greater risk of further falls.

Forward vision

- To report on falls in a more meaningful way.
- The Head of Health and Safety and the Nurse Consultant for Physical Health will visit Coventry and Warwickshire to review their local success in reducing falls utilising assistive technology.
- We will continue to form part of, and learn from, the National Falls Collaborative.
- The Falls Steering Group will govern implementation of quality improvement projects relating to falls prevention and management.
- The Nurse Consultant for Physical Health will lead on the falls strategy providing a constant oversight on the work that needs to be done to reduce falls as far as practicably possible. There will be regular meetings, training on falls prevention, the offer of falls link workers.
- Dementia and Frailty (D&F) will continue to adopt the safety thermometer which is a nationally mandated CQUIN to support a reduction in avoidable harm.
- Falls huddles will be used more consistently across the Trust, post falls, to ensure incidents are discussed and strategies identified to minimise risk.
- The Trust will learn from National Policy and Guidelines such as National Institute for Health and Care Excellence (NICE) and Royal College of Psychiatry (RCP) and implement recommendations where possible.
- The Trust will continue to offer harm reduction training packages to support staff across specialties in their knowledge and understanding of how to reduce falls; staff are attending training during April and May. There is a section dedicated to falls which is delivered by physiotherapists.
- Quality of the data within the reporting system will be more robust. Also staff rarely cite medication as a contributory cause of falls which is unlikely to be the case. These findings will be disseminated to matrons so that they can improve the quality of reporting intelligence - a review of what we report and how has been proposed.
- All patients will be offered anti-slip socks as the footwear of choice.
- There is an ongoing monthly audit within D&F looking specifically at whether staffing levels has an impact on the number of falls.

- As there is an increase in falls around mealtimes, all staff will endeavour to protect this time by reducing alternative activities such as ward administration to ensure their availability.
- Expressions of interest for falls champions from each clinical area have been sought and we are now deploying this model.

Smoke free support

An evaluation of the smoke free policy – initial results

During the year we have undertaken a detailed evaluation and audit of our smoke free arrangements in the Trust. This has included:

- to explore the views of inpatients on the Trust Smoke Free Policy
- to determine the impact of this ban on smoking status, during an admission to hospital and following discharge.

The evaluation concluded that respondents had highlighted the stress experienced by smokers when not able to obtain leave in order to smoke, and the impact this can have on relationships with staff. Some non-smokers reported a difficult ward environment due to disagreements about smoking. Most smokers returned to the previous levels of smoking following discharge, although it was positive that around one in five reported a reduction in smoking. A review of the support given to smokers during and after admission may improve the experience and outcomes and this will now be taken forward by our Smoke Free Steering Group.

Smoke free policy review

During the year we have consulted with staff and patients about our smoke free policy. We have also had support from the Institute of Psychiatry in London. As a result of this we have made changes to our smoke free policy approach to ensure:

- improved information for service users will be provided at all points of contact, to ensure that the impact of not being able to access tobacco is lessened, and that access to advice and support is much clearer
- we make clearer what the offer of support, advice and alternatives will be for service users
- an up to date position on how staff can access support, training and advice to help with implementation of the policy.

	Quarter 1		Quarter 2		Quarter 3		Quarter 4		2018/19 Total		
Indicator	**Num**	**Denom**	**Num**	**Denom**	**Num**	**Denom**	**Num**	**Denom**	**Num**	**Denom**	**%**
A - Smoking Screening	289	389	297	329	283	310	219	313	1,088	1,341	81%
B - Smoking Brief Advice	103	125	122	163	129	133	87	93	441	514	86%
C - Smoking Referral/NRT Medication	78	125	111	163	125	133	91	93	405	514	79%

Indicator Definitions

A - Smoking Screening

Numerator: Screened for smoking
Denominator: Total number admitted in quarter

B - Smoking Brief Advice

Numerator: Offered and accepted Brief Advice to stop smoking

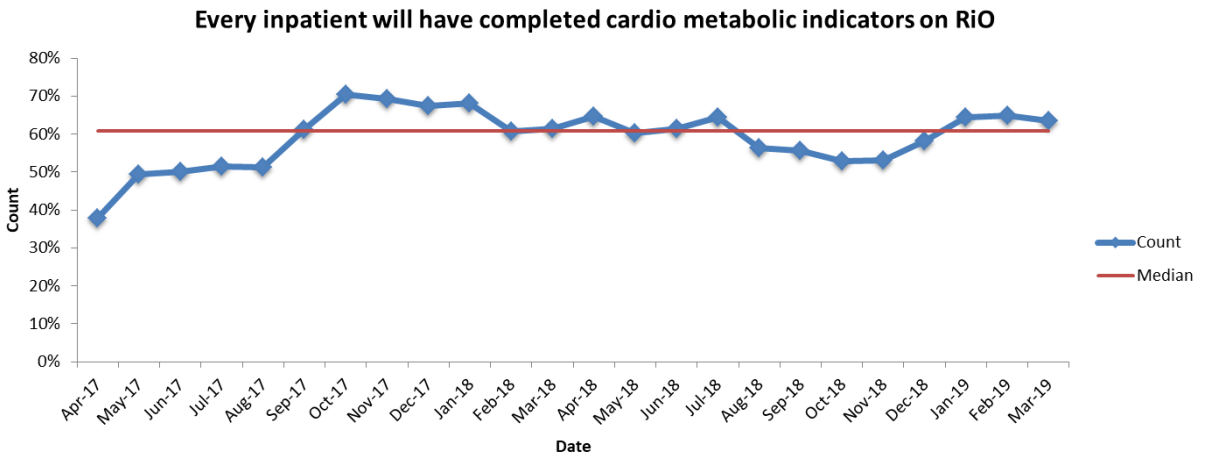
Denominator: Number of patients who smoke

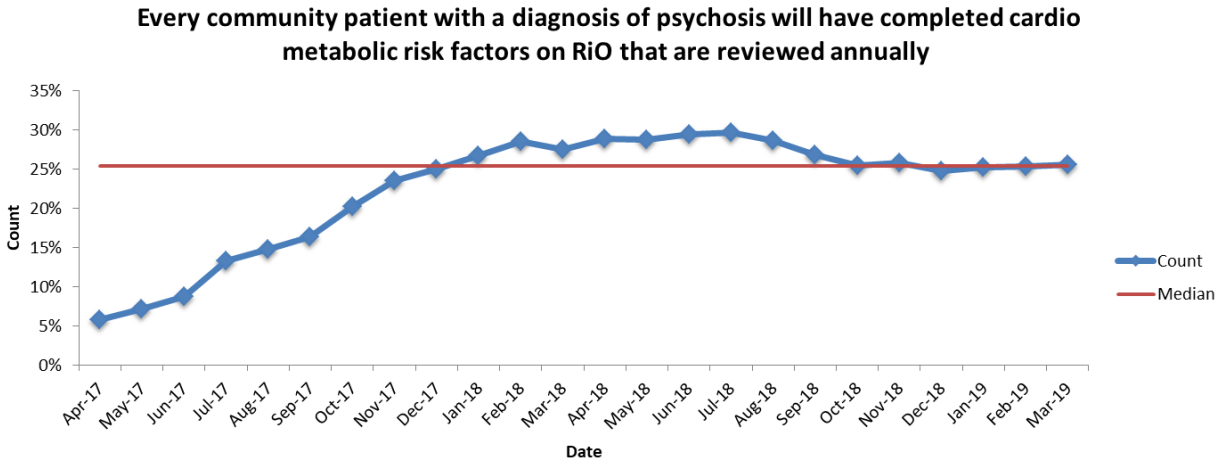
C - Smoking Referral/NRT Medication

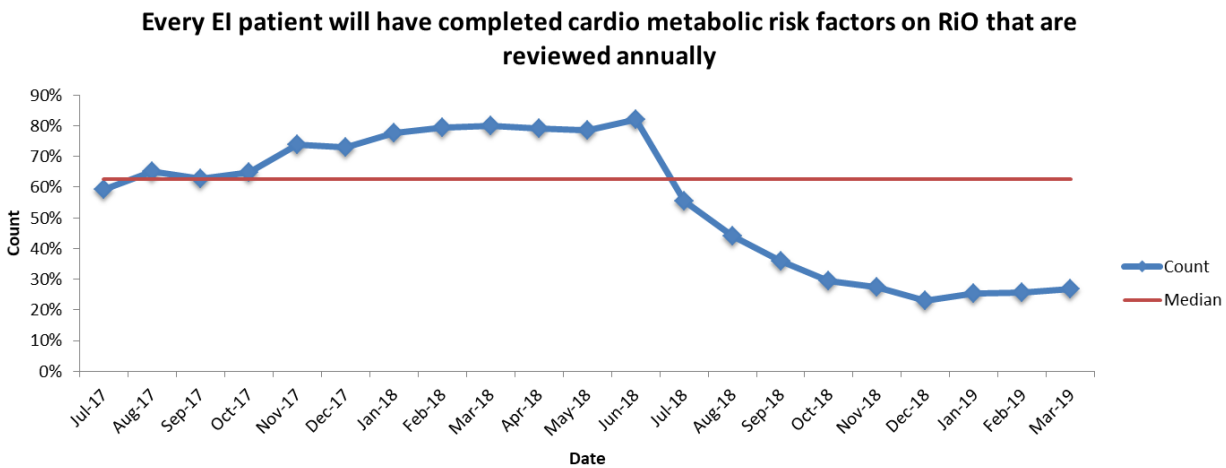
Numerator: Offered (but may have declined) NRT/Stop Smoking referral

Denominator: Number of patients who smoke

Cardio-metabolic indicators







Our approach to physical health has improved in some areas. We know from national mortality research that the life expectancy of those with a serious mental illness can reduce by approximately 15 per cent due to lifestyle choices. Over the last two years, we have increased our recording of cardio metabolic indicators such as blood glucose levels, alcohol use, tobacco use and Body Mass Index (BMI) from 38 per cent to 60 per cent of inpatients and in our community services from 6 per cent to 28 per cent. Understanding these indicators means that we are able to help provide advice and support to patients under our care in relation to diabetes, smoking cessation, alcohol and drug misuse and weight loss. One of our commitments in our strategy was to 'provide an enhanced range of physical health opportunities and activities for patients in our inpatient services'. During the two years we have funded outdoor gyms in a number of our inpatient units and, for example at Hillis Lodge, all patients are encouraged to use a pedometer to measure the steps that they are taking daily. Activities more generally across the Trust do however need to increase. We know this from the feedback from our inpatient survey in 2018/19 and from Friends and Family feedback. Our quality improvement projects will include activity related projects during 2019/20, along with two particular projects to improve the recording of physical health indicators and subsequent care planning.

A three year physical health strategy was approved through the Trust governance process in August 2018. The strategy was reviewed at the last Physical Health Committee in February 2019 and it was noted that progress is being made in all domains of the strategy. Pieces of work include:

- working with the mental health leads within the Clinical Commissioning Group (CCG) regarding communication improvements about physical health
- ongoing joint work with clinical staff and corporate colleagues regarding improving recording physical health information
- working groups around obesity management, documentation and training, all of which are designed to improve physical health care.

Safe

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.

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.

Measures of success

- Reduce number of confirmed suicides of patients on our caseload representing 20 per cent reduction compared to 16/17.
- No inpatient suicides on inpatients wards.
- No never events.
- Improvement in crisis plan measurement in the Community 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.

Our improvement measures

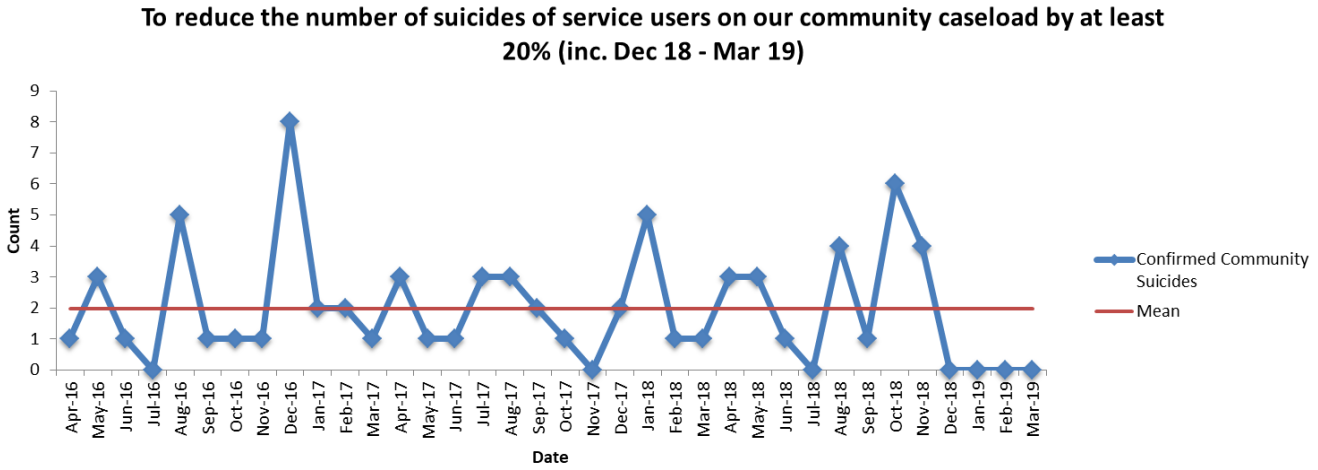
To work towards our zero suicide ambition we will:	**2016/17**	**2017/18**	**2018/19**
Reduce the number of confirmed suicides by at least 20% compared to the 16/17 figures	26	18	22
No inpatient suicides	2	1	0
No Never events	0	0	0
Improvement in crisis plan measurement in patient survey (Q21 and Q23) • S5 Section score of the Patient Survey • Q21 Do you know who to contact out of office hours if you have a crisis? • Q23 When you tried to contact them, did you get the help you needed	 6.0 5.3 6.7	 5.7 5.8 5.5	 5.8 achieved 7.2 achieved 6.8 achieved

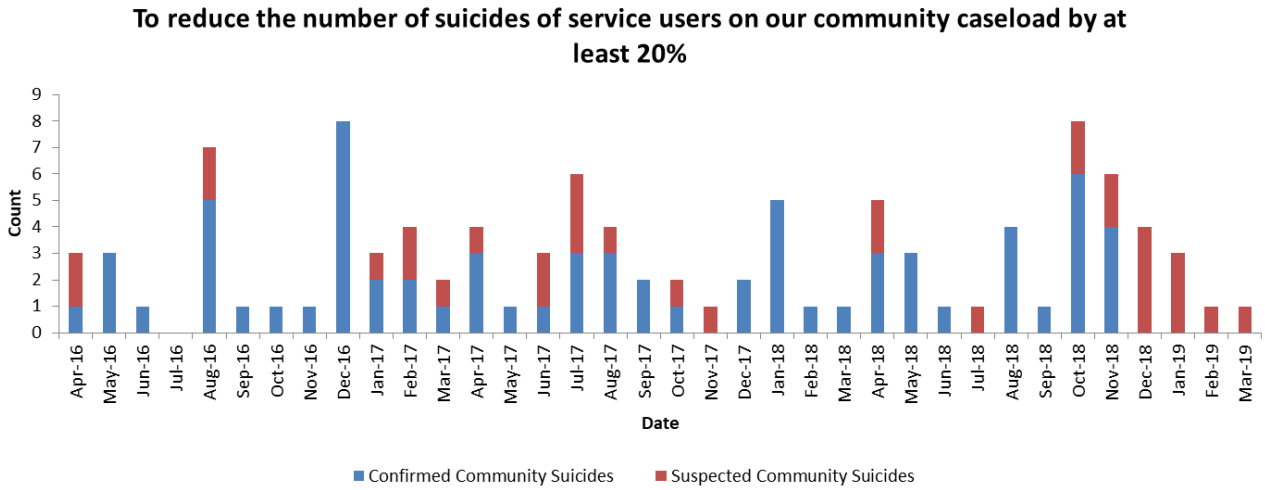
Did we achieve the goal?

Inpatient suicides

Target	**2016/17**	**2017/18**	**2018/19**	Apr 18	May 18	Jun 18	July 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
0	**2**	**1**	**0**	0	0	0	0	0	0	0	0	0	0	0	0

Community suicides





We have made some very positive progress this year against this quality goal including:

- As in previous years, there has been zero Never Events in 2018/19.
- For the first time in the three year reporting period there has been zero inpatient suicides.
- Suicide Prevention Training has exceeded our target levels and the year-end compliance rate was 98.3 per cent.
- Mortality framework fully embedded.
- Improvement in crisis plan score in community survey.
- Appointment of a Family and Carer Liaison Officer to systematically engage families and carers in investigations linked to the death of a family member who was under our care, clearly appointing one point of contact within the Trust during the time of the investigation.
- Ensured that our physical environment is as safe as possible taking account of new and innovative environmental developments including the piloting of anti-ligature door systems.
- Achieved a year on year reduction in the level of harm caused to patients through clinical incidents by ensuring that lessons are learnt from serious incidents and are embedded in practice – moderate harm and above account for 2.3 per cent of all incidents compared to an average of 3.8 per cent in other mental health trusts.

Our goal relating to a reduction in confirmed suicide levels continues to show improvement from previous years, however there is a time lag between suspected suicides being confirmed by the coronial inquest process. Nationally, we have seen further improvements in suicide levels for Birmingham as per the National Confidential Inquiry into Suicide and Homicide Annual Report 2017/18 whereby our suicide rate per 100,000 population has reduced from 9.2 per cent in 2016/17 to 8.0 per cent in 2017/18. Birmingham and Solihull has the eighth lowest suicide rate in England at the time of writing this report.

We are now nearing the end of our current Suicide Prevention Strategy and are in detailed discussion and consultation about our strategy for 2019-2022. Early indications are that we will be strengthening our response times to incidents of suicide by conducting 24 hour reviews to identify any immediate learning from suicide cases. We are also seeking to establish a patient safety response team who will work with clinicians to understand immediate improvement opportunities as well as more detailed investigations that could lead to more in-depth opportunities for learning and changes in practice, systems and/or processes. We will also work closely with our recently appointed Family and Carer Liaison Officer to ensure that consistent offers of support and engagement are made to bereaved families and carers and seek to learn from their experiences. Work will also take place with the Compassion at Work Group to formulate a consistent offer of support for staff, post incident and pre/inter coronial inquest.

Safe

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

Why is this important?

This is an extension of the quality goal in 2017/18 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 incidents 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).

Measures of success

- Reduce inpatient physical assaults on staff by 20 per cent compared to 16/17 outturn.
- Reduce inpatient physical assaults on patients by 12 per cent compared to 16/17.
- Ensure compliance with environmental and clinical standards relating to seclusion.
- Reduce incidents of prone restraint by 15 per cent compared to the 16/17 outturn position.

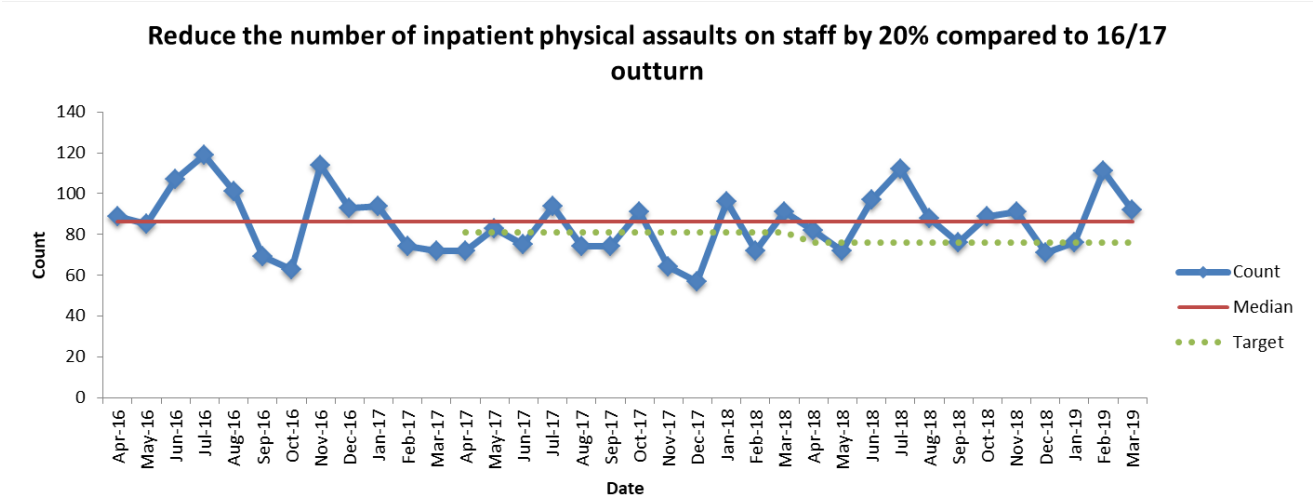
Enablers

- 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 PICUs.

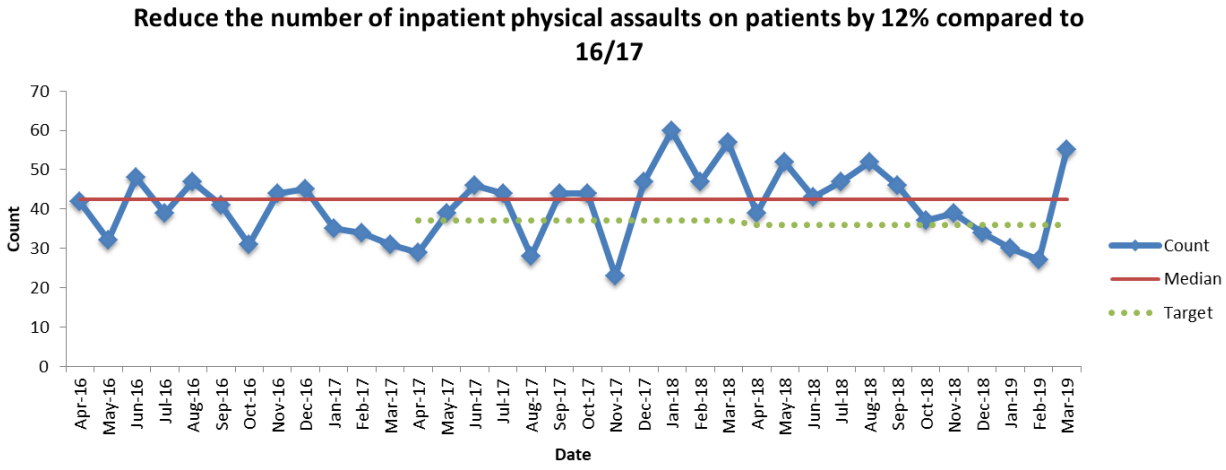
Did we achieve the goal?

	2016/17 Numbers	2017/18 Numbers	Target for 2018/19 Numbers
Reduce inpatient physical assaults on staff by 20% compared to 16/17 outturn	1,141	975	Target 913 Actual 1,057
Reduce inpatient physical assaults on patients by 12% compared to 16/17	488	544	Target 429 Actual 501
Ensure compliance with environmental and clinical standards relating to seclusion	N/A	N/A	N/A
Reduce incidents of prone restraint by 15% compared to the 16/17 outturn position	1,127	1092	Target 958 Actual 1,055

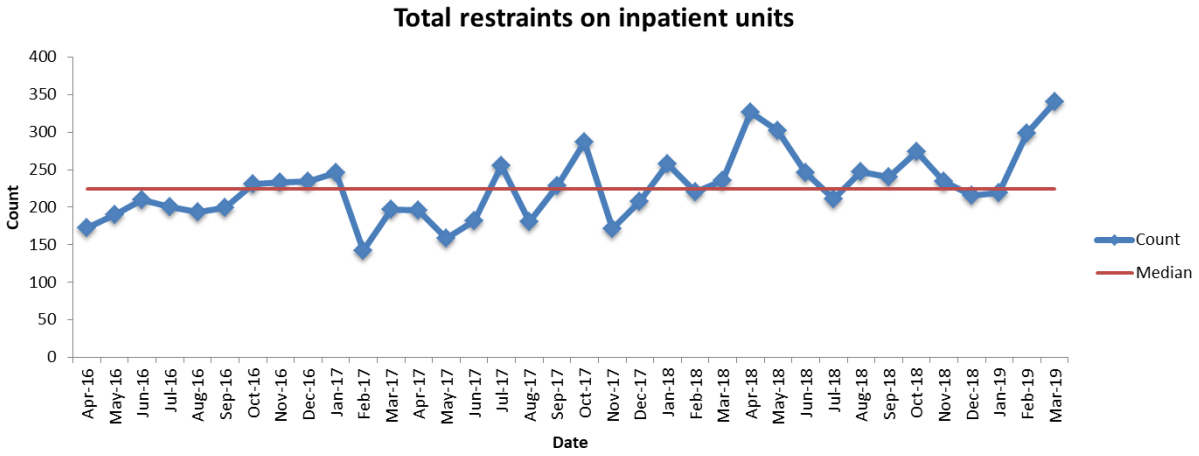
Assaults on staff on inpatient units



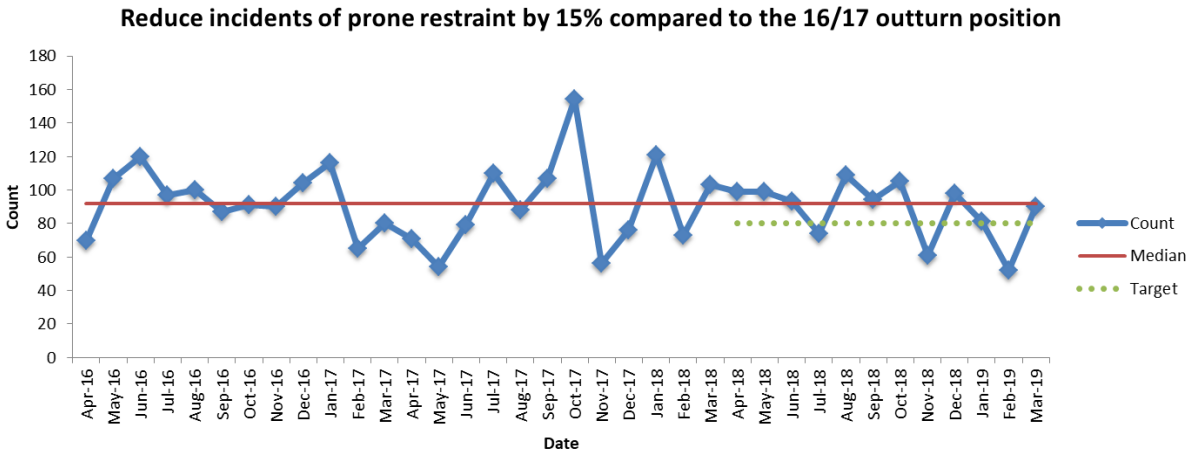
Assaults on patients on inpatient units



Total number of restraints



Prone restraints



Our journey of least restrictive practice continues and we now have Safewards in place across all of our inpatient units. Our levels of prone restraint have reduced by 14 per cent compared to 2017. At the start of this strategy NHS Improvement benchmarking showed that the Trust had some of the highest levels of restraint in the country.

Two years into our strategy, and with the expert guidance and support of our Positive and Proactive Care Expert Panel, we have moved out of the upper quartile for these incidents, and in some areas such as older people's services are now below the median line. Levels of violence have also reduced during this period, and we have also developed our relationship with Operation Stonethwaite. Our Positive and Proactive Care Expert Panel has undertaken much work to understand the experience of seclusion within the Trust and has engaged the views of patients and staff to help identify improvements that we can make to the seclusion experience.

At the end of the reporting period there were 1,057 incidents of physical assaults on staff in our inpatient units. This is an 8.4 per cent increase on the previous year's figure. It is important, however, to note the positive improvements that have been made in terms of the qualitative measures for this goal although the quantitative measures were not realised.

Effective

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

Why is this important?

This is important because it is possible to recover from mental health problems, and many people do – especially after accessing support to help, patients and carers discover which self-care techniques and treatments work best for them. For many people, recovery doesn't necessarily mean going back to how their life was before, but learning new ways to live their life the way they want to, and gaining control over areas of their life that might have felt out of control before. Co-production and family, carer and service involvement is fundamental to aiding recovery, ensuring that patients and their loved ones are able to contribute to the shape of services, new initiatives, self-help programmes, care planning and risk assessments.

Measures of success

Improvement in Q35 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.

Did we achieve the goal?

The following achievements have been made in relation to this goal:

- Recovery College is now delivered in the north of Birmingham as well as at Solihull and our central training centre Uffculme. We are also increasingly supporting the development of Recovery College in clinical areas.
- Proactive links are being made with the third sector to increase opportunities and smoother transition for service users within communities. The third sector organisations Better Pathways, Mind and Creative Support provide employment support from within our community mental health teams, and recovery opportunities in Birmingham.
- Connections are being forged with adult education with a view to integrating this within Recovery College.
- The review of the Family and Carer Strategy is complete.
- The Family and Carer Steering Group has been attending service area meetings and working with teams to support the implementation of the new family and carer pathway.
- The three action groups within the Recovery for All strategy are now established. They have agreed their work priorities:
    - Systems – review of RiO paperwork (RiO is our electronic patient record), policies and exploring the use of a co-production quality kite mark to be awarded for work which fulfils the 3 x Cs (co-production, co-design and co-delivery).
    - Workforce – to review to the model used for peer support and to support people who have lived experience and are employed within the Trust.
    - Communication – the launch of the strategy was held in February 2019, this will now be rolled out through the Trust via roadshows.

The service user surveys have indicated that overall there has been some improvement in how we work with service users and how we include families. We will continue to seek further improvements as the work is further embedded. The Trust is now in the process of embedding the family and carer pathway throughout the service areas.

	2017	**2018**
Q35 Community Patient Survey score	6.0	6.6

Our quality priorities for 2019/20

Our quality priorities for 2019/20 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 via its public meeting. The priorities largely focus on the delivery of year three of our Quality Strategy upon which we widely consulted in 2017 prior to Trust Board approval in March 2017. The priorities also reflect feedback from the national patient survey, learning from our serious incidents, our staff survey and patient feedback on issues such as their experience of restraint, seclusion and wider restrictive practice. We also focus on feedback from our Care Quality Commission inspection including feedback given by patients, families and carers.

Our quality priorities for year three 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 (Well Led).

Measures of success

- Appointment of centralised quality improvement experts.
- Broader workforce capacity and capability will be in place in quality improvement methodologies and delivery.
- Formal quality improvement projects will be in place for a number of our quality goals during 2019/20.

Enablers

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

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.
- Year on year increase in recording of cardio metabolic assessment of inpatients and community patients with a diagnosis of psychosis compared to April 2017.

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.

Cardio-metabolic indicators

- Review how data is reported and shared with clinicians, to ensure it is more useful and effective (for example, team or service specific, breaking down the six cardio-metabolic indicators, review where information originates).
- Physical Health Committee to work with clinical teams to increase awareness of the importance of recording cardio-metabolic indicators and working with service users to address areas of clinical need.

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 30 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.
- Implement three day post discharge follow up and ensure a care plan is in place at the point of inpatient discharge.
- Approval and implementation of our new Suicide Prevention Strategy.

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 16/17 outturn.
- Reduce inpatient physical assaults on patients by 12 per cent compared to 16/17.
- Ensure compliance with environmental and clinical standards relating to seclusion.
- Reduce incidents of prone restraint by 15 per cent compared to the 16/17 outturn position.
- Eliminate seclusion outside a dedicated seclusion facility.
- Improve patient experience of restrictive interventions when they need to occur.
- Improve consistency of processes relating to restrictive practices.

Enablers

- Increase staff awareness of support following an assault, including via Operation Stonethwaite, and increase use of the Police Interventions Policy and reporting proforma when appropriate (this will be supported by a QI project).
- Gradual introduction of using Positive Behavioural Support principles and plans in inpatient areas, in conjunction with the ongoing process of embedding and use of existing Safewards modules supported by the AVERTS Department/AVERTS consultants.
- Specific QI projects related to reducing length of seclusion episodes, and improving service user and staff experience.
- Increase use of debriefs for service users after restrictive interventions, and inclusion of feedback in care plans and advanced statements.

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

- Development of standard and criteria for a quality mark for coproduction in at least one setting.
- Increased activity of service users and carers through experts by experience and Recovery for All opportunities.

Enablers

- 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 programme including signposting for carers and carers' assessments.
- Utilise the learning from the employment experience of peer support workers to develop the model of peer support.
- Implementation of Recovery for All Strategy Action Group activity.
- Implementation of Experts by Experience Programme.
- Continuation of Recovery College.
- Implementation of the Family and Carers Strategy.

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 2018/19, 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 2018/19 represents 100 per cent of the total income generated from the provision of relevant health services by BSMHFT for 2018/19.

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 2018/2019 8 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 2018/19 are as follows:

- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Annual Report 2017 (NCISH).
- National Clinical Audit of Anxiety and Depression (NCAAD)
- National Clinical Audit of Psychosis – Early Intervention in Psychosis Spotlight audit
- National Clinical Audit of End of Life Care
- National Clinical Audit of Anxiety and Depression (NCAAD) - Psychological Therapies Spotlight Audit
- Prescribing Observatory for Mental Health (POMH)
  - Topic 16b: Rapid Tranquilisation
  - Topic 18a: Prescribing Clozapine
  - Topic 6d: Assessment of the side effects of depot antipsychotics
  - Topic 7f: Monitoring of Patients prescribed Lithium

The national clinical audits and national confidential inquiries that Birmingham and Solihull Mental Health NHS Foundation Trust participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or inquiry 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	Yes	Yes	Unavailable
National Clinical Audit of Anxiety and Depression (NCAAD)	Yes	Yes	100% (100 patients)
National Clinical Audit of Psychosis – Early Intervention in Psychosis Spotlight audit	Yes	Yes	100% (65 patients)
National Clinical Audit of End of Life Care – Organisation Level Audit	Yes	Yes	n/a
National Clinical Audit of Anxiety and Depression (NCAAD) - Psychological Therapies Spotlight Audit	Yes	Yes	100% (202 patients)

POMH Topic 16b: Rapid Tranquilisation	Yes	Yes	79[1]
POMH Topic 18a: Prescribing Clozapine	Yes	Yes	95[1]
POMH Topic 6d: Assessment of the side effects of depot antipsychotics	Yes	Yes	147[1]
POMH Topic 7f: Monitoring of Patients prescribed Lithium	Yes	Yes	109[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 5 national clinical audits were reviewed by the provider in 2018/19 and Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Learning from national clinical audits

POMH topic 16b: Rapid Tranquilisation

The Trust took part in a baseline audit relating to rapid tranquilisation in 2017. This re-audit in 2018 was focused on rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour. The Trust submitted data for 79 patients in total, all of whom had received rapid tranquilisation as a result of an episode of acutely-disturbed behaviour on one of our wards during March and May 2018.

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 8 occasions where patients in our sample received IM haloperidol. Of these, 100 per cent had evidence of an ECG within the last 12 months. This is an improvement since the initial audit in 2017 where practice around this standard was poor.

However, the results also showed a few areas for further improvement. For example, although we had improved in making sure that a prompt debrief occurred following an episode of rapid tranquilisation, the audit showed that the Trust is not doing this all of the time. In this respect, we are still 29 per cent below the national average for prompt debriefing following rapid tranquilisation. Further to this, the Trust has declined in its performance for monitoring physical health in the hour following rapid tranquilisation. This means that the Trust falls below the average performance reported by the national sample, particularly in relation to monitoring temperature, pulse and blood pressure.

In response to these results, the Trust has agreed on a number of key actions:

- Collaborative working with the Physical Health Committee around improving monitoring of physical health following rapid tranquilisation. This work will be further supported by the roll-out of the rapid tranquilisation observation app Trust wide. The app reminds staff of the correct timings for physical health monitoring following rapid tranquilisation; provides a centralised place for recording measurements; and prompts staff when observations are overdue. Full implementation of the app Trust wide will improve patient safety by ensuring that physical health monitoring happens in a timely manner and measurements outside of normal parameters are flagged.

- Collaborative working with the Positive and Proactive Care Expert Panel (PPCEP) around improving the timeliness of debriefs and quality of care planning following rapid tranquilisation to manage any further episodes more effectively.

- Other actions include updating the Trust Rapid Tranquilisation Policy and training material in order to strengthen understanding of at risk patients in the context of rapid tranquilisation.

POMH topic 15b Prescribing Valproate for Bipolar Disorder

In September 2017, the Trust gathered data for 97 patients with a primary clinical diagnosis of Bipolar. The number of female patients of child bearing age (18-50) in our sample, who were being prescribed Valproate, was higher than that of the total national sample. Further to this, the audit showed that we were below the national average for annually monitoring the physical health of patients on valproate.

One month before the results of this audit were disseminated, the Medicines and Healthcare products Regulatory Agency (MHRA) changed the license for prescribing Valproate. The regulatory change stipulates that Valproate must no longer be prescribed to women or girls of childbearing potential unless they are on the Pregnancy Prevention Programme (PPP). As such, healthcare professionals who seek to prescribe valproate to their female patients must make sure they are enrolled in the PPP - this includes the completion of a signed risk acknowledgement form by the patient and the specialist when treatment is reviewed, at least annually.

In response to both the findings of the audit and the new regulatory changes, the Trust developed a robust action plan which included:

- Work to bring all prescribing of valproate onto a centralised, electronic prescribing system. This will provide better oversight, improved monitoring, and more robust scrutiny of Valproate prescribing.
- Arrangements to ensure that any valproate prescribing by our specialist clinicians adheres to the Pregnancy Prevention Programme. This includes making sure that the annual risk acknowledgment form is completed in collaboration with the patient.
- Updating the Trust Bipolar guidelines and the prescribing guidelines for women of childbearing potential, to ensure that these are in line with the national Valproate Pregnancy Prevention Programme requirements.

Early Intervention in Psychosis Network (EIPN)

In 2017 the Trust took part in an Early Intervention in Psychosis audit, the report for which was received in April 2018. The audit measured Early Intervention services against three main areas – timely access; effective treatment; and outcome measures. The results of the audit showed that our Early Intervention Team is a level 4, top performing trust in relation to number of standards:

- Offering timely access to treatment - 100 per cent compliance.
- Offering Cognitive Behavioural Therapy for Psychosis (CBTp) - 80 per pent compliance.
- Offering family interventions - 83 per cent compliance.
- Offering carers support - 87 per cent compliance.

Areas where the Trust was found have the greatest need for improvement was in recording at least 2 clinical outcome measures at least twice and, making sure that full physical health assessments were carried out for people who have been on the caseload for six months. This included looking at smoking status and BMI.
In response to findings of the audit the Trust agreed to:

- Continue with the timely access programme, making sure patients with first episode psychosis commence treatment within 2 weeks of referral to the service.
- Improve physical health interventions with the introduction of smoking cessation and other lifestyle programmes at weekly 'drop in' sessions. To monitor progress, the Trust participated in a further spotlight audit in 2018 looking at the impact of physical health interventions on smoking and weight gain. We are awaiting the results if this audit.
- Introduce new outcome measures on our electronic patient record system and train staff in the use of these.

National Clinical Audit of Psychosis (NCAP)
In November 2017 the Trust participated in the National Clinical Audit of Psychosis run by the Royal College of Psychiatrists. The Trust submitted data for 200 patients, 168 of whom were community patients with a diagnosis of schizophrenia or schizo-affective disorder. The results of the audit showed that the Trust was below the national average (of 42 per cent) for measuring all 5 cardiovascular disease risk factors for the patients under our care. Further to this, the Trust was also below the national sample in offering physical health interventions for each of the 5 cardiovascular disease risk factors measured.

An area where the Trust did particularly well and has improved in since earlier audits was in monitoring alcohol consumption (84 per cent) and offering interventions for excessive alcohol intake (80 per cent). Further to this, 93 per cent of patients in our sample had a care plan and 91 per cent of these, had care plans containing basic information about crisis contact. In terms of prescribing, 66 per cent of the patients in our sample had recorded evidence that they had been involved in the prescribing decision. This is significant improvement since earlier audits.

In response to the findings of this audit our Trust Physical Health Committee developed a new physical health strategy with the ultimate aim of improving the physical health care of our patients. The strategy, which was published in June 2018, looks at addressing a number of key aspects of physical health care for both inpatients and outpatients. It sets out a number of specific aims and tasks, but focuses largely on obesity; staff training in relation to physical health assessment; and the management and documentation of physical health measurements.

National Confidential Inquiry (NCI) into Suicide and Homicide
The 2018 annual report from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) provides findings relating to people who died by suicide or were convicted of homicide in 2006-2016 across all UK countries. Additional findings are presented on sudden unexplained deaths under mental health care in England and Wales. The report shows that the lowest rate of suicide in the country is 6.9 per 100,000 in Nottinghamshire, the highest is Cornwall and Isles of Scilly at 14.4. Birmingham and Solihull have a rate of 8.0 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. There are 2 pilots currently in place for anti-ligature bedroom and en-suite doors on the female PICU and female acute wards.
- Good progress with reducing absconding from inpatient units.
- Post inpatient discharge follow up – The assessment identified some challenges in achieving effective qualitative three day post discharge follow up and this therefore continues to be an area of focus for us during 2019/20.

The reports of 77 local clinical audits were reviewed by the provider in 2018/19 and Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Learning from local clinical audit

Safewards	This audit looked at compliance around embedding the ten Safewards modules across the Trust as part of our violence reduction plan. This supports our quality goal to reduce violence on our inpatient wards. Safewards is an evidence based 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 (DH, 2014) and the new NICE Guideline (NG: 10) Violence and aggression: short term management in mental health, health and community settings (NICE, 2015). The results of the audit showed that Trust wide, all of our inpatient service areas had some level of Safewards compliance. Where reduced compliance was indicated, this was associated with new service areas and specialist services that are adapting the Safewards model to meet the needs of their service users. Further to this, service user feedback during this audit was overwhelmingly positive with regards to the elements of Safewards. In response to the findings of the audit, work around embedding Safewards modules will continue. Support will continue to be offered to staff in adapting the existing frameworks and being creative around its implementation to suit service user needs as part of the embedding process. Further to this, work is needed to be done to embed Safewards terminology into reporting and recording. This will provide invaluable evidence that Safewards is becoming 'business as usual' in care delivery.
Annual Adherence to Mental Health Act Consent to Treatment Paperwork within	This annual audit looks at the extent and nature of adherence of Consent To Treatment (CTT) paperwork to the requirements of the Mental Health Act and Care Quality Commission (CQC) guidelines, when prescribing medication. The looked at prescribing for 294 service users from 45 teams within our Trust.

BSMHFT	A total of 308 CTT forms were audited. Though the re-audit showed an improvement in practice since the previous audit, there were still a small number of breaches in prescribing. In response to these results, a number of recommendations have been established to improve compliance. These include: • Pharmacists prioritising checking prescribing adherence to MHA CTT paperwork at each ward visit. • Ward managers ensuring that a hard copy of the most up to date MHA CTT paperwork is available on the ward. This will assist nursing staff when checking medication is authorised by the MHA CTT paperwork prior to administration to a service user. • Discussing CTT paperwork in the multi-disciplinary team meetings so that the approved clinician can ensure that the service user's medication is authorised by the CTT paperwork.
Compliance with Waterlow assessment and re-assessment process	This audit looked at compliance with the use of the Waterlow Pressure Ulcer Risk Assessment Tool. Trust policy relating to the Prevention and Management of Pressure Ulcers currently states that the tool should be used for all service users who are admitted to our inpatient wards. Ideally, this should be within 24 of admission in order to identify individuals who may be at risk of developing pressure ulcers. The results showed that Trust compliance with using the Waterlow, in terms of its application and timeliness, requires improvement. Additional feedback gathered by the Tissue Viability Lead Nurse whilst collecting data for the audit, suggested that staff did not feel the tool was appropriate for our patient population. Following on from this audit and in response to this feedback, the Tissue Viability Nurse for the Trust submitted a proposal to replace the existing Waterlow Tool with an alternative tool. Having researched what alternatives were out there, the Tissue Viability Nurse felt that a tool called the Purpose-T risk assessment would be more suitable for our inpatient population because the questions are more appropriate. Further to this, the tool is simpler to use and quicker to complete. A pilot using the new tool took place on a selection of wards and in line with this; training in its use was delivered. The proposal for the new tool will now need to be considered and approved by the Trust Clinical Governance Committee.

Research

The number of patients receiving relevant health services provided or sub-contracted by Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 1,034.

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 2018/19 financial year there were 20 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 bipolar 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. Scoping has begun to set up a new LEAP group (Lived Experience Advisory Panel) which will bridge the gap between research and our service user participation.

Commissioning for Quality and Innovation (CQUIN) 2018/19

Use of CQUIN payment framework

A proportion of BSMHFT income in 2018/19 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.

Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically at https://www.bsmhft.nhs.uk/about-us/trust-documents/statutory-statements-and-declarations/cquins-2017-19/

CCG's Contract CQUINs

No.	CQUIN Scheme	Weighing	Value
1a	Introduction of health and wellbeing initiatives	4%	£128,860
1b	Healthy food for NHS staff, visitors and patients	4%	£128,860
1c	Improving the uptake of flu vaccinations for frontline clinical staff	4%	£128,860
3a	Improving physical healthcare to reduce premature mortality in people with SMI: Cardio metabolic assessment and treatment for patients with psychoses	6%	£193,290
3b	Improving physical healthcare to reduce premature mortality in people with SMI: Collaboration with primary care clinicians	6%	£193,290
4	Improving services for people with mental health needs who present to A&E	12%	£193,290
5	Transition out of Children and young people's mental health services	12%	£386,581
9a	Preventing ill health - alcohol and tobacco - screening	0.8%	£386,581
9b	Preventing ill health - alcohol and tobacco - tobacco advice	2.3%	£24,161
9c	Preventing ill health - tobacco referral and medication	3%	£72,484
9d	Preventing ill health - alcohol screening	3%	£96,645
9e	Preventing ill health - alcohol brief advice or referral	3%	£96,645
L1a	Scheme to support engagement with STPs	20%	£96,645
L1b	Linked to the risk reserve	20%	£644,302
		100.00%	**£3,221,508**

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

Our predicted end of year CQUIN position is 85.8 per cent completion, paying £2,763,651 subject to achievement of our quarter 4 submission.

The 14.2 per cent loss is due to:

- Partial achievement of 'Introduction of health and wellbeing initiatives', 'Improving the uptake of flu vaccinations for frontline clinical staff', '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'.

NHS England CQUINs (Secure and Specialties Contracts)

No	CQUIN Scheme	Weighing	Value
MH2 Secure	Recovery Colleges for Medium and Low Secure Patients	25%	£278,236
MH3 Secure	Reducing Restrictive Practices within Adult Low and Medium Secure Services	25%	£278,236
MH4 Secure	Discharge and Resettlement from Specialised MH Inpatient Services	50%	£556,473
		100%	£1,112,946

MH4 Specialties	Discharge and Resettlement – Reduction of Length of Stay in Specialised MH Inpatient Services	50%	£168,046
MH5 Specialties	CAMHS Inpatient Transitions	50%	£168,046
		100%	£336,093

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. BSMHFT has the following conditions on registration – none. The Care Quality Commission has not taken enforcement action against Birmingham and Solihull Mental Health NHS Foundation Trust during 1 April 2018 to 31 March 2019.

Birmingham and Solihull Mental Health NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 1 April 2018 to 31 March 2019.

- Core Services Inspection (Rating of Requires Improvement) of:
  - acute wards for adults of working age and psychiatric intensive care units
  - mental health crisis services and health-based places of safety
  - wards for older people with mental health problems
  - child and adolescent mental health wards
  - forensic inpatient/secure wards.

- Trust wide Well Led inspection (Requires Improvement)
- Core Inspection of the Health Exchange (homeless services) – Inadequate Rating

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

Core services and well led inspection

- The Trust must ensure that on wards that did not have fixed nurse call buttons in patients' bedrooms, staff mitigate the risk this posed by assessing whether individual patients, who might be at risk or otherwise be vulnerable, should be provided with a portable alarm to request assistance if needed. Regulation 12 (1)(2)
- The Trust must ensure that the prescribing, administration, and monitoring of physical health of patients are completed as detailed in Trust policy and NICE guidelines within acute care [NG10] on-Violence and aggression: short term management in mental health, health and community settings. Regulations 12(1)(2)
- The Trust must ensure that there are sufficient numbers of suitably qualified, competent and skilled staff on each ward. Regulation 18(1)
- The Trust must ensure that staff have appropriate supervision and appraisal to enable them to carry out the duties they are employed to perform. Regulation 18 (2)
- The Trust must ensure section 62 paperwork is reviewed and that referrals are made to a SOAD in a timely manner. Regulation 17 (2)
- The Trust must ensure that governance systems and processes at ward level assess, monitor and improve the quality and safety of services provided in the carrying on of regulated activity. Regulation 17(2)
- The Trust must ensure that in its mental health crisis services and health based place of safety, systems and processes are in place to identify where quality and safety are being compromised and to respond appropriately and without delay. This includes the quality of the experience that patients receive in those services. Regulation 17 (2)(a)
- The Trust must ensure staff follow the Trust medicines policies. There was no system in place to accurately monitor medicine stocks within the home treatment teams. Staff were not transporting medicines in a secure container to patient’s homes and they did not always record and dispose of controlled drugs appropriately. The fridges in the psychiatric decision unit were not secured appropriately. Regulation 12 (1)(2)(b)
- The Trust must ensure that staff have access to an alarm system or personal alarms to alert others in the case of an emergency in the Psychiatric Liaison Team. Regulation 12 (1)(2)
- The Trust must ensure they have enough facilities such as appropriate rooms to speak to patients at the Oleaster unit when they are seen on trust premises. Regulation 15 (1)(c)
- The Trust must ensure environmental risk assessments at Ashcroft and Reservoir Court are up to date and actions completed. Regulation 17(1)(2)
- The Trust must ensure that staff have access to an alarm system or personal alarms to alert others in the case of an emergency at Ashcroft. Regulation 12(1)(2)
- The Trust must ensure that patient identifiable information is secure and cannot be accessed by unauthorised people within Dementia and Frailty Wards. Regulation 17(1)(2)
- The Trust must ensure staff always follow best practice when storing, dispensing, and recording the use of medicines. Regulation 12(1)(2)
- The Trust must ensure that all risk assessments in forensic and secure care are complete and up to date. The information contained within must be personised and specific to the individual. Regulation 12(1)(2)(a)

- The Trust must ensure that care plans are personalised, specific and recovery focused. Regulation 9(1)(2)(3)
- The Trust must ensure that there are no unnecessary blanket restrictions in place at the Tamarind Centre. Regulation 13(1)(4)

Action the Trust should take to improve. This action related to four areas:

Trust wide
- The Trust should ensure that the Board Assurance Framework and risk assessments documents are kept together.

Acute wards for adults of working age and psychiatric intensive care units
- The Trust should ensure that the prescribing of valproate/valproic acid to females of childbearing age is undertaken following national guidance and staff ensure they record this activity in patients care records. Regulation 12 (1)(2)
- The Trust should ensure that all staff at Mary Seacole House adhere to the Trust no smoking policy.
- The Trust should ensure that staff record seclusion reviews as per Trust policy.
- The Trust should ensure that care plans are holistic, recovery orientated and personalised, and that patients are offered a copy of their care plan.

Mental health crisis services and health-based places of safety

Wards for older people with mental health problems
- The Trust should ensure staff received both managerial and clinical supervision and this is recorded effectively.
- The Trust should ensure they know where visitors are on the ward and give them access to a nurse call alarm.
- The Trust should ensure staff establishment levels are accurate for the service.
- The Trust should ensure adequate medical cover is in place across all wards.
- The Trust should ensure all staff are appropriately supported and debriefed following all instances of abuse or incidents.
- The Trust should ensure there are development opportunities for all staff and staff are aware how to access these.
- The Trust should ensure carers are appropriately involved in patient's care and given the opportunity to engage and feedback.
- The Trust should ensure care records reflect where carers have been contacted and actions taken by staff.
- The Trust should ensure complaints are managed effectively and resolved with all parties and any actions followed up.

Forensic inpatient or secure wards
- The Trust should ensure that staff record information on their electronic database in a consistent way.
- The Trust should ensure that all staff receive regular management and clinical supervision.
- The Trust should ensure that governance processes operate effectively at Reaside Hospital and The Tamarind Centre. Regulation 17(2)(a).

Birmingham and Solihull Mental Health Foundation Trust has made the following progress by March 2019 in taking such action – the CQC report was not received until 4 April and the Trust is in the process of developing a comprehensive suite of actions to address the regulatory issues highlighted above.

Health Exchange – CQC Inspection was carried out on 25 July 2018.

Following formal notification of a CQC Inadequate rating for the Heath Exchange the service set out an action plan to rectify all outstanding matters identified by the CQC. During the same period the commissioners requested a separate service review by Royal College of General Practitioners (RCGP) Practice Support team, which is undertaken whenever a Birmingham and Solihull Primary Care Practice has an inadequate report.

The CQC final report confirmed that the Health Exchange received two Requirement Notices breaching the following Regulations.

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The table below identifies:

The actions the service was required to undertake. The Health Exchange had already embarked on creating and implementing and a comprehensive action plan.

The commissioners commissioned the services of the RCGP and following its review implemented a Forward Plan for the Health Exchange. The Trust completed an Assurance Framework of the journey the Health Exchange was continuing and this has been and will be ongoing. The Health Exchange has undertaken a great deal of work and this has been supported by the RCGP.

The CQC re-inspected the service at the start of April 2019 and we await their written report and rating of the service.

Action 1	
Ensure care and treatment is provided in a safe way to patients (1)	
Item 1	Legionella Risk Assessment
Item 2	Fire Risk Assessment
Item 3	Control of Substances Hazardous to Health (COSHH) Risk Assessment
Action 2	
Ensure care and treatment is provided in a safe way to patients (2)	
Item 1	Emergency drugs. All recommended drugs should be available on site and in date. There should be a risk assessment in place for any drugs which the practice decides not to stock.
Item 2	Protocols for dealing with medical emergencies should be available and shared with all staff.
Item 3	An infection control audit should be completed and practice specific infection control protocols available to and shared with all staff.

Action 3	
Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care (1) - cleaning	
Item 1	Establish a robust practice specific cleaning protocol.
Item 2	Establish regular in-house monitoring to ensure compliance.
Action 4	
Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care (2) - patient experience	
Item 1	Introduce Practice level Family and Friends Test. Collate Friends and Family Test results and submit using Calculating Quality Reporting Service (CQRS) so that data is showing nationally for the practice. CCG to help set up of CQRS programme.
Item 2	Review results of National GP Patient Survey and take any appropriate actions.
Action 5	
Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care (3) Non-clinical Governance	
Item 1	Establish appropriate in-house non-clinical policies compliant with CQC requirements and which are shared with the whole team.
Item 2	Establish regular review of all non-clinical policies.
Item 3	Establish a robust system for rapid action in the event of holiday or sickness absence to ensure appropriate staffing levels.
Item 4	Review IT systems to ensure compliance with all primary care needs in accordance with CQC. Including care-plan templates.
Item 5	Ensure all staff have smart-card access and that they use them.
Action 6	
Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care (4) clinical governance	
Item 1	Develop robust in-house clinical policies compliant with CQC which are shared with all appropriate staff. Practice to look at current forums and platforms to access draft practice policies (e.g. First Practice Management) and to engage with the CCG to provide GPTeamNet so that the sharing of in-house documents can be monitored and stored.
Item 2	Establish regular review of all clinical policies.
Item 3	Ensure that there is a robust policy for communication with out of hours providers (OOH) and that this is appropriately supported by the IT system. To discuss with CCG methods of communication with OOH Providers and to implement (e.g. Adastra Electronic Patient Information Management System).
Action 7	
Take action to ensure advance training carried out by clinical staff is recognised and staff complete training recognised by the service as mandatory in a timely fashion	
Item 1	Practice to invest in Primary Care specific training tools for all staff (e.g. Blue Stream) and put in place a robust system to review this.

Action 8	
Take action to gain patient feedback and explore effective ways to act on feedback in order to improve patient satisfaction	
Item 1	See action 4.
Item 2	Consider a tailored patient questionnaire to seek views specific to the patient demographic.
Item 3	Audit of waiting times (low result In GP Survey), both to review the actual waiting times for booked and walk-in appointments (Education Management Information System - EMIS capability) and to assess the patient view as to whether they feel these are acceptable. Further action will depend on outcome.
Item 4	Establish some form of PPG. This may need innovative organisation in view of the transient population. It might for example be worth enrolling all registering patients and encouraging them to comment on specific topics.
Action 9	
Completion of Trust CQC Compliance Review	
Item 1	All Patient notes to be summarised within 8 weeks of receipt. Identify summarising expertise and funding to complete the backlog of records not summarised. Protocol for summariser to follow and robust policy for ensuring appropriate handling of records.
Item 2	Outstanding task on the new works refurbishment to be completed
Item 3	Fire drills to be completed at least quarterly (to be arranged with the Salvation Army). Weekly alarm tests to be carried out. Fire test logs to be updated and maintained on site. Fire Test/Drill Policy to be in evidence and policy lead identified.
Item 4	KPI Outcome Measures need to be agreed with the CCG Commissioners and can be measured using EMIS reports. The Faculty for Homeless Health 'Standards for Commissioners' may be a useful document to aid this.
Action 10	
Staffing Levels and Staffing Needs	
Item 1	Ensure that there is GP provision over 5 days (Monday to Friday). There is currently a need to provide a GP on Fridays.
Item 2	Requirement for a Clinical Lead for the practice who is based at the practice.
Item 3	Requirement of a Primary Care Management support/presence at the practice.
Item 4	Ability to advertise Primary care vacancies at the practice in a variety of ways to reach target audience.
Action 11	
Patient Communication	
Item 1	Establishment of a Practice Website (e.g. My Surgery website) to enable the practice to have full control of information for patients. It would also raise the practice profile, which would enable other agencies to access the surgery appropriately and may aid recruitment.
Item 2	Out of hours (OOH) information to be provided to patients. The practice leaflet and NHS Choices website need to be updated to provide the information, and the answerphone needs to be enabled to inform patients appropriately and direct them to the OOH service.
Item 3	Review of patient leaflet to ensure compliance with contract standards.

Action 12	
Establishment of Practice Specific Clinical Protocols	
Item 1	Blood result protocol to be created to include safety netting of blood results taken during outreach work.
Item 2	Appropriate recording of contacts with non-registered patients.
Action 13	
Technology requirements	
Item 1	As there is not always a GP on site, it would be advantageous if nurses could refer directly for some radiology, which is possible if they are appropriately trained.
Item 2	Practice engagement with enhance services. CCG to review current enhanced services for those applicable to the practice (e.g. Tuberculosis, Long Acting Reversible Contraceptives, flu etc.). Practice to acquire CQRS access for the data collection of enhanced services if applicable.
Item 3	CCG to support practice engagement with Quality and Outcomes Framework (QOF). The practice needs to train all staff to collect data appropriately and to monitor collection to achieve optimal scores, bearing in mind that short patient registration time will limit the ability to get maximum scores.
Action 14	
Contracting Issues	
Item 1	Contract to be reviewed to enable better contract oversight, detailed KPIs and performance indicators and to allow a greater openness and transparency of the service.
Item 2	Full review of Practice Contract Pricing which has remained static since 2011 despite an increased practice population.
Item 3	Review CQC registration. There needs to be a discussion regarding a possible change of CQC Registered Manager and services provided to sit in line with that of a Primary Care organisation.
Action 15	
Risk Management	
Item 1	Risk needs to be better captured at practice level and institution of a local practice risk book would assist. All staff members should have access to this.
Item 2	Oversight of the local risk book by senior risk management would ensure that risk was appropriately escalated.
Action 16	
Practice visibility	
Item 1	Practice presence on Primary Care Web tool.
Item 2	Practice information on Open Prescribing.

Since this inspection, the CQC have re-inspected the service and informal feedback suggests:

The practice now has clear systems to keep people safe and safeguarded from abuse. Staff provided examples of where referrals have been made which resulted in positive outcomes. Staff demonstrated high knowledge of safeguarding procedures within the service.

The service demonstrated effective management of infection control and monitoring of actions which have been completed.

The service had arrangements to ensure that facilities and equipment were safe and in working order.

Effective clinical waste management.

Staff worked together and with other health and social care professionals to deliver effective care and treatment. For example, joint working with outreach teams, homeless discharge nurses in secondary care; diabetic specialist nurses, mental health teams and substance misuse services. The service is aware that the recording of work carried out with other professionals is an area which the service is addressing.

There were adequate systems to assess, monitor and manage environmental risks to patient safety. For example, fire and health and safety risk assessments were in place. The practice had reviewed and improved the stock of medication for managing medical emergencies. There was further work required to ensure the emergency medicines is specific for primary care provisions.

Improving data quality – Data sets: NHS number and general medical practice code validity

Birmingham and Solihull Mental Health NHS Foundation Trust submitted records during 2018/19 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:

- 99.2 per cent for admitted patient care
- 99.8 per cent for outpatient care.

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

- 98.6 per cent for admitted patient care
- 98.9 per cent for outpatient care.

Information governance toolkit attainment levels

Birmingham and Solihull Mental Health NHS Foundation Trust's Information Governance Toolkit Assessment report has been replaced by a new system and Birmingham and Solihull Mental Health NHS Foundation Trust's Data Security and Protection Toolkit for 2018/19 was assessed as standards not fully met.

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.
- Ongoing 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.

Reporting against core 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. Five 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. 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 (CPA) 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
2018-19	96.1%	95.7%	100%	82.8%
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 Liaison Psychiatry (LP) 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
2018-19	97.1%	98.1%	100%	88.5%
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+
2018-19	0.0%	5.8%
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 2018 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 2018 relating to satisfaction with health and social care workers. The 2018 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
2018-19	7.1	6.8	7.7	5.9
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:

- Continue the rollout of the Trust wide Recovery Strategy – there are now three action groups and they have all created a work plan.
- Continue to promote the Crisis Line through information posters, leaflets and branding.
- Continue to design and roll out co-designed recovery training delivered by Experts by Experience. We have also introduced a new Experts by Experience Introductory Session and four additional Skills Sessions in a schedule repeating quarterly.
- Update, redesign and distribute the Buzz Guide mini-directory to all services detailing over 130 wellbeing and support services.
- Improve information on medications and side effects. The Trust contributes financially to the www.choiceandmedication.org/bsmhft website. To consider better ways to advertise this through pharmacy's medication packs, staff training and Connect intranet.

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 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 18 – Sep 18	44	49	114	25	0.4%	0.82%	6.25%	0.09%
Oct 17 – Mar 18	41	45	97	15	0.4%	0.98%	63.64%	0.00%
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%

	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 18 – Sep 18	5233	44	22	0.4%
Oct 17 – Mar 18	4788	41	21	0.4%
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%

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 via incidents awareness sessions and Incident Manager training.
- We are developing practice guidance as part of an updated 'Reporting, Management and Learning from Incidents' policy.
- Introducing governance and incident reporting at the junior doctors marketplace, preceptorship training and at Student Experiential Learning Pathway sessions.
- We have introduced shorter incidents forms on Eclipse for easier completion.
- 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 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. This corresponds with question 21(d) in the 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
2018-19	53.1%	61.3%	80.8%	38.2%
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 2018

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

- The survey is undertaken independently to the Trust by an external company in accordance with national survey requirements.

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 internal engagement work. This will help us to develop a renewed set of actions based on staff feedback and involvement.

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 550 of the 636 deaths reported via our incident reporting system during the year.

So far 38 of the deaths have been subject to a Mortality Case Note Review and 24 a Serious Incident Root Cause Analysis investigation. Of these, 3 of the deaths were identified as probably avoidable.

Within the 3 deaths associated with a problem with care, there are some emerging themes that we need to act upon in 2019/20 to ensure that we learn from these cases in the future. The issues identified from the three cases included lack of professional curiosity in risk assessment, gaps in service due to communication in interagency working, involving family and carers in the assessment process, involving medics at an earlier point and access to out of hours medics, and the management of cancelled appointments. These all feature within aspects of our Quality Goals for the Trust for 2019/20.

During April 2018 – March 2019, 636 of BSMHFT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
155 in the first quarter;
162 in the second quarter;
172 in the third quarter;
147 in the fourth quarter.

By 14 March 2019, 38 case record reviews and 24 investigations have been carried out in relation to 636 of 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:
0 in the first quarter;
4 in the second quarter;
18 in the third quarter;
39 in the fourth quarter.

Three, representing 0.48 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:
0 representing 0 per cent for the first quarter;
0 representing 0 per cent for the second quarter;
1 representing 0.58 per cent for the third quarter;
2 representing 1.44 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 number the lessons learned were more specific to each case rather than wider thematic style learning. However we have still taken the opportunity to learn from these cases and improve the quality of care we provide throughout the Trust as a whole.

The issues identified from the three cases included lack of professional curiosity in risk assessment, gaps in service due to communication in interagency working, involving family and carers in the assessment process, involving medics at an earlier point and access to out of hours medics, and the management of cancelled appointments.

There was also some specific learning taken from an individual team which was around the use of senior/experienced staff taking crisis calls from patients and ensuring the appropriate handover takes places following crisis calls.

Following the lessons learnt we have implemented the following actions:

- The Trust's mandatory 'Clinical Risk Assessment and Management' (CRAM) training has undergone a thorough review and update; it is currently going through governance with a view to piloting the new training in summer of this year. The training will include a focus on professional curiosity.
- There are plans to review the dual diagnosis policy, to look at how we work together and share information with external providers of drug and alcohol services.
- The Trust's mandatory 'Suicide Prevention Training' is also currently being reviewed and will include more content surrounding interagency working and information sharing between teams.
- A new family and carer strategy has been developed and is currently being piloted in a number of areas. This focuses on identifying carers for every single patient, capturing their information and ensuring they are involved in the patient's care.
- The Medical Directorate is currently undertaking a workforce review to look at access and utilisation of out of hours medics and how we can best improve this. There is also a future plan to review operational policies for functional teams including how and when medics are accessed out of hours.
- The individual team as previously discussed has implemented actions to ensure only senior nurses are taking crisis calls, and that handover to relevant teams are sent via email and followed up by phone call.

Due to the scale of work involved in the actions listed above it would premature to evaluate the outcome.

The individual team report an improvement in management of crisis calls, with more fluid handovers and sufficient follow up. There have been no further incidents of the same nature to date.

There were 31 case record reviews and 21 investigations completed after March 2018 which related to deaths which took place before the start of the reporting period.

Four, representing 7.7 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 number has 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.

Twelve, representing 1.55 per cent of the patient deaths during April 2017-March 2018 are judged to be more likely than not to have been due to problems in the care provided to the patient.

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 (SOF).

National Mental Health Indicators

	NHS Improvement Single Oversight Framework (SOF) updated in November 2017: National Indicators – 2018/19	National Threshold	2017/18	2018/19
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. Ⓐ	53%	90.5%	98.7%
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% 75%	 70.87% 59.2% 24.5%	 64.8%* 25.7%* 25.5%*
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%	 50.4% 96.8% 100%
4	Care programme approach (CPA) follow-up: proportion of discharges from hospital followed up within 7 days	95%	96.1%	96.1%
5	Admissions to adult facilities of patients under 16 years old	n/a	0	0
6	Inappropriate out-of-area placements for adult mental health services (average bed days per month) ** Ⓐ	n/a	138	566.75

** For 2017/18, out-of-area placement figures cover January to March 2018 only as this measure was added to national performance reporting frameworks from January 2018.

Service demand has been very high across Acute and Urgent Care throughout the year. During the month of March 2019 for example, 75 service users detained on section 136 were assessed in Place of Safety with 45 of those requiring beds. This, in addition to the referral rates from Home Treatment and Liaison Psychiatry is putting excessive pressure on BSMHFT beds and requiring out of area beds to be utilised.

Ⓐ See Annex 4

*Cardio-metabolic indicators figures to be confirmed - NHSI's SOF states that compliance against this measure relating to physical health assessments will be triangulated with the outcomes of the physical health CQUIN which is part of the national annual audit, the results of which are not yet available.

Section Three

Review of Quality Performance

Safety

- Clinical risk assessment policy and training
- Junior doctors rotas
- Searching and security
- Safeguarding
- Anti-ligature improvements

Effectiveness

- Care Programme Approach
- Accreditations
- PLACE results 2018 (Patient Led Assessments of the Care Environment)

Experience

- NHS Friends and Family Test
- Families, friends and carers engagement
- See Me service user engagement
- Complaints investigations – highlights and challenges
- Freedom to Speak Up
- Trust and staff awards
- Dragons' Den

Safety

Our Trust identified the following key indicators for monitoring the quality of safety in addition to the indicators in chapter 2 of this report.

Safety indicators

	2016/17	2017/18	2018/19
Numbers of Incidents reported	17,588	16,291	19,342
RIDDOR reportable incidents	33	85	57
Serious incident reports (by date of incident)	123	100	91
Serious incident reports (by reported date)	121	105	92
Clostridium Difficile Infections	**0**	**0**	**0**
Never Events #	**0**	**0**	**0**
MRSA infections	**0**	**0**	**0**
Level 1 Suicide Prevention Training	84%	96.8%	98.3%
Health and safety training	97.1%	95%	97.8%
The management of violence and aggression training – AVERTS 5 day training	98.4%	97.4%	96.5%

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.

There is an increase in the overall numbers of incidents reported in 2018/19, which demonstrates a culture of good reporting, allowing the organisation to learn and improve. The number of serious incidents has also decreased for the second year in a row. There has been an increase in the compliance rate for health and safety and suicide level one training. In the case of the latter, this has increased by 14 per cent compared to the 2016/17 figures.

Clinical risk assessment policy and training

At the beginning of last year the Clinical Risk Assessment and Management Policy underwent a fundamental review by the then 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 2019/20 we will be revitalising the training to ensure it meets the needs of clinicians and develops their skills and confidence appropriately.

Junior Doctors' Rotas

BSMHFT has a Guardian of Safer Working Hours who acts as a champion of safe working hours for junior doctors. He is responsible for overseeing compliance with the safeguards outlined in the 2016 terms and conditions of service (TCS) for doctors and dentists in training. The Guardian identifies issues and either resolves or escalates them to the Trust Board as well as providing assurance to the Trust Board that issues of compliance with safe working hours will be addressed, as they arise.
The Trust currently has a 30% gap within our on call rotas .The key reasons for this are:

- vacancies mainly due to shortage in supply of trainees
- removal of some doctors from the rota for maternity and medical reasons.

We have undertaken a review of our rotas in order to streamline work and reduce gaps through the amalgamation of junior doctor rotas. We have reduced the allocation of doctors per rota to a 1 in 9 from 1 in 11 and we have merged one of these rotas across two other rotas. Currently doctors have reported an improvement with these alterations. However, we are closely reviewing the situation, taking account of feedback from the Junior Doctors Forum, Exception Reports and the Guardian of Safe Working as well as gathering information across the ST4-6 rotas to ensure we reduce gaps effectively. A review of consultant rotas has also been undertaken.

Additionally, to ensure effective out of hours cover the following has also been put in place:

- On call Handbook (which is issued to all trainees and consultants) has been updated following feedback from services/medical staff and has been re issued.
- Arrangements have been made to ensure all rotas are available on the Trust Intranet Emergency Planning Pages for all to view electronically.
- Locum Work guidelines and Working Time Directive Requirements have been issued to all Doctors and available on the Trust Intranet Emergency Planning pages on Connect for all to view electronically.
- New procedure for Acting Down arrangements is being agreed with Joint Local Negotiating Committee (JLNC) and will be issued shortly.
- Annual Leave Policy and cover arrangements for medical staff during work hours and out of hours are being developed with the JLNC.

Searching and Security

Following the implementation of the new search and security management policies last year, further work has been done to improve safety for patients and staff who access Trust buildings. This has included close partnership working with our private finance initiative (PFI) colleagues to develop a working procedure for the utilisation of security staff to support with searching in some inpatient reception areas. The provision of this resource has in the main reduced some burden on clinical staff enabling them to focus on a more therapeutic relationship with patients. Security staff have been trained in Mental Health First Aid and have received a local induction from the Trust's Local Security Management Specialist (LSMS). A number of items with the potential to cause harm to staff and patients have been retrieved from other patients during the searching process in this area. While there were a few points for improvement with this process, it has largely been seen as a positive move and it is anticipated that this service will be rolled out to the bigger outpatient and community buildings as well.

Safeguarding

Quality improvement measures

In 2018/19 The Safeguarding Team began work on refreshing the Trust's Safeguarding Strategy whilst continuing with a three year project to develop a new clinical quality assurance framework with associated audit programme. Our first tranche of safeguarding practice guidance was finalised in January 2018 and was launched in order to support the 'mainstreaming' of safeguarding as a routine aspect of all clinical contacts and interventions. In order to achieve our overall aim of a positive safeguarding culture we have reviewed the corporate support offered to operational services and it is evident this support has not engendered independent delivery of local safeguarding sufficiently, and our refreshed strategy will need to address this. We believe that to truly encourage quality improvement our governance and assurance arrangements needs to be tightened and that our new strategy will need to include changes to the Strategic Safeguarding Committee. During 2018/19 adherence to policy has been audited to benchmark operational practice to quality standards – this is underway and not yet complete.

Learning into practice

The Safeguarding Team continues to promote a learning culture. During 2018/19, the Named Nurse for Domestic Abuse organised a conference aimed at improving clinical staff's response to domestic abuse in line with the Birmingham Domestic Abuse Strategy. This was attended by Trust staff including the Chief Executive and Executive Director of Nursing and by invited partners. It was very well received.

We conducted a thematic review to discern how learning from domestic homicide reviews and other serious case reviews has been picked up by operational services. In response to our findings the Head of Safeguarding and Named Nurse for Domestic Abuse delivered a lecture to senior managers and executives which illustrated the repeated themes with the aim of encouraging a positive operational response towards implementing practice improvements.

The team continues to recognise good practice by distributing Safeguarding Best Practice Awards. We have awarded 13 so far during 2018/19.

In order to promote key themes and messages the team produce a “Safeguarding Message of the Month” which is attached to our emails and is included in the “Connected” e-magazine. An example of this can be viewed here.

Working in Partnership

The Safeguarding Team has participated in numerous partnership forums during 2018/19. The Head of Safeguarding has taken up the role of Chair of the Safeguarding Adult Review Sub Group of the Birmingham Safeguarding Adult Board and the group has commissioned two reviews in this timeframe.

Significant improvements have been made to our processes and attendance at Multi Agency Risk Assessment Conferences (MARAC) and two of our staff have been trained to chair these meetings by Safer Lives.

Anti-ligature improvements

The Trust has a robust system in place for identifying ligature risks in the clinical environment and making recommendations for removing or reducing those risks. A part of this process has included the introduction of a Ligature Risk Reduction Policy to provide guidance for staff for managing these types of risks. Risks that are identified through the multi-disciplinary risk assessment approach with the Estates Team and clinicians are shared with relevant staff as part of an action plan. These plans are discussed in local health and safety committees where plans are formulated for implementation of corrective actions. From here these actions form part of the submission of works detailed on the Trust’s capital programme. As a result of this process a significant amount of ligature risks have been removed from inpatient areas.

A similar process has also commenced for the review of community patient buildings following the release of “Preventing suicide: A toolkit for community mental health”. The ligature risks in the waiting areas of such buildings are documented along with locally agreed mitigation.

As part of the ongoing commitment to safety and ensuring that patients are as safe as possible during their inpatient stays, the Health and Safety and Estates Teams have worked closely with external suppliers to develop anti-ligature products that were not commercially available. The main product has been the anti-ligature door, which is currently being trialled on two wards in the Trust; one on a female psychiatric intensive care unit (PICU) and the other on a female acute ward. There are two different products being trialled and these will be evaluated at the end of the period and a recommendation made to the Trust as to which will most efficient at supporting patient safety. These will also be considered for any future new builds or refurbishment of existing wards.

Effectiveness

The Trust identified the following key indicators for monitoring effectiveness. These were identified in the previous report and following review, they were still deemed to be a priority.

For people on CPA	2016/17	2017/18	2018/19
Completion of CPA care plan	88.3%	82.4%	83.4%
Completion of level 1 risk screening tool	86.3%	81.9%	81.9%
Completion of Assessment Summary (previously known as the Health and social care assessment)	86.9%	81.5%	80.2%
CPA review in the previous 12 months	92%	97%	95.8%
For people on Care Support	**2016/17**	**2017/18**	**2018/19**
Care Support Care plan	61.3%	63.5%	66.6%
Level 1 Risk Screening Tool	50.5%	52.3%	51.6%
Assessment Summary	67.3%	69.9%	73.3%

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 has 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.

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 these 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.

Care planning training programme

The CPA Team has 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 has now extended training to student nurses who will be working within this Trust as part of the Student Experiential Learning Framework (SELP).

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:

- Dan Mooney House ***Solihull***
- David Bromley House ***Solihull***
- Grove Avenue ***South***
- Forward House ***North and West***
- Endeavour Court ***North and West***
- Hertford House ***Solihull***

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 Liaison Psychiatry
- City Liaison Psychiatry
- Good Hope Liaison Psychiatry

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.

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.

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 is accredited with ECTAS.

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
- Deaf Service (Jasmine Suite) – Accredited by the Quality Network for Inpatient Mental Health Services for Deaf People.
- Perinatal Mental Health Team (Birmingham Women's Hospital) – Peer review took place on 13 March 2019, and the outcome is awaited.

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.

PLACE results 2018 (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). The current PLACE assessment also covers criteria on how well healthcare providers' premises are equipped to meet the needs of caring for patients with dementia (introduced from the 2015 assessments) and how well equipped the premises are to meet the needs of people with disabilities (introduced from the 2016 assessments). It should be noted that these do not represent a comprehensive assessment relating to dementia or disability; rather these focus on limited ranges 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. It should also be noted that best practice suggests that an Independent Reviewer (who does not form part of the assessment team) is present at the assessments; this is not mandatory but is recommended.

For all of BSMHFT's 21 assessments, service user representatives made up at least 50 per cent of the team and 100 per cent of the assessments had an Independent Reviewer present.

The Team comprised of:

- two or three service user representatives
- matron
- facilities representative (stood down if less than three service user representatives)
- PLACE Administration Manager (from Estates and Facilities).

(Independent Reviewer – does not form part of the team but can offer advice if required).

How did we do?
For cleanliness, BSMHFT is one of 12 NHS trusts who have scored 100 per cent and are joint top scoring nationally. This is the second year in a row that the Trust has achieved 100 per cent in this category.

BSMHFT's overall organisational scores are an increase on its 2017 scores for all six categories (Cleanliness, Food and Hydration, Privacy, Dignity and Wellbeing, Condition, Appearance and Maintenance, Dementia and Disability).

- BSMHFT is one of only 12 Trusts that scored 100 per cent for **Cleanliness.**
- BSMHFT is in the **top scoring 10 per cent** of NHS trusts for **Food and Hydration.**
- BSMHFT is in the **top scoring 4 per cent** of NHS trusts for **Privacy, Dignity and Wellbeing.**
- BSMHFT is in the **top scoring 6 per cent** of NHS trusts for **Condition, Appearance and Maintenance.**
- BSMHFT is in the **top scoring 5 per cent** of NHS trusts for **Dementia (Environment).**
- BSMHFT is in the **top scoring 9 per cent** of NHS trusts for **Disability (Environment.**

BSMHFT's overall organisational scores exceeded the national average scores in all six categories once again.

BSMHFT's 2018 PLACE Scores			
Category	**BSMHFT Overall Score**	**National Average Score**	**BSMHFT's score compared to other trusts**
Cleanliness	100%	98.5%	Joint top score of all NHS trusts
Food and Hydration	96.21%	90.2%	in top 10% of all NHS trusts
Privacy, Dignity and Wellbeing	96.87%	84.2%	in top 4% of all NHS trusts
Condition, Appearance and Maintenance	99.13%	94.3%	in top 6% of all NHS trusts
Dementia (Environment) (introduced 2015)	95.58%	78.9%	in top 5% of all NHS trusts
Disability (Environment) (introduced 2016)	95.94%	84.2%	in top 9% of all NHS trusts

Previous years' scores

Cleanliness	Food and Hydration	Privacy, Dignity and Wellbeing	Condition, Appearance and Maintenance	Dementia (Environment) (introduced 2015)	Disability (Environment) (introduced 2016)
BSMHFT's 2017 PLACE Scores					
100%	96.06%	94.12%	97.71%	93.64%	89.86%
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%		

At the end of 2018 and the beginning of 2019 a national review of the PLACE Assessments commenced please see below for the details.

PLACE assessment review 2018/19

During 2018/19 NHS Improvement has undertaken a review of the PLACE Assessment Process (which has been running for six years). This has taken the form of regular meetings of a focus group made up of all the stake holders involved in PLACE including: NHS Trust Estates and Facilities professionals, CQC representatives, NHS Digital, AHCCP (Association of Health Care Cleaning Professionals), HCA (Hospital Caterers Association), service user groups, nursing representatives and specialist interested parties such as Age UK, dementia associations and many others.

BSMHFT is represented on the national review group with BSMHFT's PLACE Lead being a member of the focus group as well as being a member of the working group undertaking the review of the processes (when should the collection take place, data entry and so on).

The focus group meets a minimum of once per month with working groups meeting between these meetings. The review is looking at all aspects of PLACE to include the timing of the assessments, the format of the paper work, the questions, scoring methodology, methods of inputting the data and many other aspects of the assessments.

The aim is to complete the main part of the review by end of March 2019 with the 2019 assessment to commence in September 2019. Smaller revisions may take place after this to refine the assessment process.

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	2018/19
Patient survey 'do you know who to contact out of office hours if you have a crisis?'	58% (69%)	57% (69%)	60% (71%)	73% (71%)
Number of complaints received	131	157	164	152
Timeliness of complaints	99%*	100%	100%	100%
% of dissatisfied complainants	33 – 25%	24 returned - 15.28%	11 returned - 6%	7 returned- 4%
Number of referrals to the Ombudsman	8	5	5	8
Number of PALS contacts/resolution	906	885	934	756
FFT score	88%	86%	87%	88%

(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	**654**	**1,057**	**989**	**1,180**
Likely	**324**	**528**	**455**	**532**
Neither Likely or Unlikely	**46**	**84**	**73**	**83**
Unlikely	**25**	**49**	**28**	**29**
Extremely Unlikely	**50**	**64**	**39**	**52**
Don't know	**15**	**33**	**21**	**26**
Total Responses	**1,114**	**1,815**	**1,605**	**1,902**
Percentage Recommended	**88%**	**87%**	**90%**	**90%**

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 our intranet, 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 the following:

- 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 are to attend user forums at Small Health and Zinnia for patients to directly ask about medications and side effects.

See Me – our service user engagement team

My experience, my service, my recovery

Our See Me 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 See Me 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 (CGCs), 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 See Me 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 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 See Me 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 and investigations – highlights and challenges

Our Customer Relations Patient Advice and Liaison Service (PALS) service strives to resolve concerns at the earliest possible opportunity for the complainant, working closely and collaboratively with clinical colleagues within services in order to achieve this. This work continues diligently behind the scenes. The cases that we cannot resolve may become formal complaints after every attempt to resolve locally has been exhausted. PALS has attempted to resolve 756 cases during 2018/19. Unfortunately, where this resolution process has failed in that, we have received 156 formal complaints registered for 2018/19. However, this is a reduction from 2017/18 data of 4 per cent.

During the first part of the year the continued improvement in the timeliness of complaint responses was evidenced, with 100 per cent of complainants receiving a written response to their complaint within the agreed response time. 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 2018/19 was 35.9 days; 2017/18 was 34.1 days. During 2016/17 the average was 38.7 days.

A slight increase has been identified during the period of 2018/19 compared to 2017/18; this has been the result of difficulty in sourcing investigating officers.

We have relaunched the Customer Relations feedback questionnaire in January 2019. At the time of writing this report, we have achieved an increase in feedback being received by 50 per cent. The theme that we have received from the feedback thus far, is that Customer Relations achieved the process of complaints handling and that our responses are clear and concise.

We have continued to see a significant reduction in the number of complainants returning to us after they have received their response, with a 2 per cent decrease from 2017/18.

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 as a Trust, or anything more we can put in place as recommendations. This process is completed in a more efficient time than previously, so complainants are not kept waiting for a second response. This is achieved generally within a 14 day window; complainants are advised if further analysis is required. Ratification of the Complaints Policy is ongoing; this will be discussed at all appropriate meetings across the Trust for a collation of comments. We have plans to deliver regular complaints training sessions, or refresher training where required, to provide updates to staff on the changes to the September 2016 policy during quarters 1 and 2 of 2019/20. 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.

Finally, we are concentrating heavily during 2019/20 on the feedback of themes following a complaint investigation, working closely and collaboratively with the Patient Experience Team, service user forums, volunteers and carers. Innovative ways of cascading this information will be introduced independently through the individual service areas throughout this period to promote maximum improvement.

Freedom to Speak Up

In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS trusts and NHS foundation trusts in England to report annually on staff who speak up (including whistle-blowers). Ahead of such legislation, NHS trusts and NHS foundation trusts are asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment.

BSMHFT has a number of ways to enable staff to do this. These mechanisms include our Freedom to Speak Up (FTSU) Guardian whose role is promoted through posters at Trust locations and on the intranet. The Guardian actively links in with the Trust's staff networks, which are sponsored by an Executive Board member, and the Trust has a network of bullying and harassment advisors who can also offer staff support. The FTSU Guardian has an agreed reporting path to the Chief Executive, the Director of Nursing for quality and patient safety matters, the non-executive director lead for equality and diversity issues and the Trust's Chair. The FTSU Guardian is supported on a day to day basis by the Company Secretary.

The Trust organises 'Listen-Up' sessions where Executive Board members visit Trust sites to listen to staff concerns. The Trust has a 'Raising Concerns' Policy, managed by our Human Resources Team, that deals with and advises on speaking up issues as and when they arise.

Trust and staff awards

BSMHFT staff were shortlisted for a number of categories at this year's Leading Healthcare Awards. This resulted in our Trust and its partners being announced as winners for two categories.

The Leading Healthcare Awards celebrate digital innovation across the health sector and highlight the organisations that are using technology to improve patient care and working practice.

Our winners were for the Physical Observation App as part of Digital Ward and the work under the MERIT programme to share information and manage beds better across Trusts.

Winners

Patient Safety Category
The Physical Observation 'App' – is the second phase of the Digital Ward project, enabling clinicians to record physical observations at the point of care and for a service user's observation history to be accessible to all health professionals involved in their care.

Case Study of the Year
The MERIT programme – has developed technology that allows clinicians at four NHS Trusts in the West Midlands to access service users mental health records, make more efficient use of inpatient beds and reduce the incidence of out-of-area placements.
James Reed, Chief Clinical Information Officer at BSMHFT, said 'We work hard to improve our use of technology so that our service users get the best care, so it's a real honour for our Trust to have received this level of recognition at these prestigious awards.
We have already been recognised for our innovative approach to technology. In 2017, our Trust was named as a 'Global Digital Exemplar' in recognition of its status as one of the most advanced IT organisations in the NHS. Projects include introducing thousands of digital observations on wards and a ground breaking Avatar Relationship Training Tool for clinicians."

Shortlisted
The other projects that we were shortlisted for and their categories are as follows:

Efficiency Savings of the Year
Avatar Relationship Tool – encourages service users to engage in their therapeutic work through a virtual world. It combines avatar technology and Mentalisation Based Therapy.

Hybrid Mail – at the touch of a button, medical correspondence is processed offsite, printed, folded, put in an envelope (with any attachments necessary) and posted from a central location and delivered to patients. It also allows for correspondence to be diverted to entirely electronic transmission if appropriate which saves further time and money.

Innovation of the Year
The Digital Ward project has introduced mobile technology and digital working to BSMHFT to transform the way healthcare professionals capture and access clinical information.

Improving Outcomes
Reach Out is a partnership of NHS Trusts and a private provider. Together they have implemented a new care model that reduces the amount of service users in secure care who are placed outside of the West Midlands away from loved ones, which impacts on their recovery journey.

BSMHFT Quality and Excellence Awards 2018

These awards started in the Trust in 2014 and provide the opportunity to celebrate and recognise individuals and teams from across the Trust for their outstanding contribution to our services for the benefit of service users, carers and their colleagues. The winners and those shortlisted for the various categories in 2018 are summarised below.

Rising Star
Aimed at individual staff that are new to the organisation (less than a year) who have made a positive impact in their role. Maybe they have demonstrated quality in their everyday work or have set a good example for the team.
Gold: Adele Linthwaite, Trust Tissue Viability Lead and Continence Advisor, Infection Control, Juniper Centre
Silver: Emily Jones, Staff Nurse, George Ward, Highcroft
Bronze: Louisa Worth, Caffra Suite, Oleaster

Excellence in Partnership Working
This award is for any individual or team that has forged strong links with partners, whether that is local GPs, commissioners, community organisations, local agencies, suppliers or other NHS Trusts.
Gold: Rookery Gardens Team
Silver: Community Engagement Team, B1 and Dr Aula Meki, Little Bromwich Centre
Bronze: Communications and Marketing Team

Volunteer of the Year
This award is for any Trust volunteer who has shown compassion and commitment to quality through their voluntary role with the Trust.
Gold: Joseph Gray. Catering Assistant, Uffculme
Silver: Charlotte Hamer, Meet and Greet Volunteer, Recovery for All
Bronze: Rhysha Gallo, Honorary Assistant, Psychological Services, Zinnia Centre

Promoting Equality and Diversity and Inclusion
This award is for any individual or team who has promoted equality, diversity and inclusion within the Trust and/or in our communities.
Gold: Tripta Sidhu and Kulsuma Begum, Psychological wellbeing Practitioners, Birmingham Healthy Minds, Little Bromwich Centre
Silver: Beresford Dawkins, Community Engagement Manager, Community Engagement Team, B1
Bronze: Akilah Duffus, See Me Service User Engagement Worker, See Me Team

Innovation and Improvement for Quality
The simplest ideas are often the most effective solutions. This award is for individuals or teams who have done things differently to improve the experience of service users, carers or colleagues.
Gold: Governance Intelligence Team and RIO Team, B1
Silver: Merit Programme, Project Management Office Team, B1
Bronze: Ashley-Christopher Fallon, Male Gender Strategy Group, Multi-Disciplinary Team, Tamarind Centre

Team of the Year
This award will be presented to a team that has shown how excellent team working has improved staff engagement and satisfaction and enhanced quality of care and experience for our service users and their carers.
Gold: PLACE Team, Estates and Facilities Team, B1
Silver: Liaison and Diversion Team, Ardenleigh
Bronze: Solihull Home Treatment Team, Lyndon Clinic

Unsung Hero
This award is for an individual who goes the extra mile in what they do. Our unsung heroes are always willing to do what it takes to achieve a positive outcome. This special award will be given to someone who provides outstanding contribution and commitment above and beyond the call of duty.
Gold: Ann Moore, Ward Clerk, Jasmine Suite, National Deaf Services, The Barberry
Silver: Phil Presland, Informatics Manager, Performance and Innovation, B1
Bronze: Dr Aula Meki: Clinical Psychologist, Older Adult CMHT, Little Bromwich Centre

Service User and Carer Choice
Our service users and carers are invited to nominate an individual member of staff who has made an outstanding contribution to their care. Whether that's someone who always shows compassion in the care they give, or someone willing to go out of their way to help improve the experience of our service users and carers.
Gold: Ann Brady, Healthcare Assistant, Dove Unit, Reaside
Silver: Matthew Meredith-Storer, Staff Nurse, Eating Disorders, The Barberry
Bronze: Amber Annand, Occupational Health Assistant, Eating Disorders, The Barberry

Dragons' Den
Dragons' Den is an initiative that has been run by the Trust for a number of years that gives staff and service users a chance to make a bid to pitch their service improvement, innovation or new idea to a panel to get the resources, support, expertise or funding they need to make a change that makes a difference for service users or staff.

In the last year a number of ideas were submitted and some successful bids include:

Sensory room on older adult ward
The ward manager and matron for one of the older adults services described the increasingly agitated nature of patients on one of the wards in this service. They explained how this change was being driven by; a younger, fitter cohort, increased medication sensitivity and a tendency towards escalating acuity on admission.

They explained how subtle changes to colours, smells and lighting in an environment can have a strong impact on behaviour. They described their wish to get additional lighting equipment and distracting tactile and visual stimuli to encourage relaxation asking for £7,500.

The Dragons particularly complemented the style of the presentation which ended with a poetic flourish. The Dragons asked how the room would support recovery plans and if there would be service user involvement in designing the space. The pitchers explained how de-escalation would be part of a care plan where triggers were identified. The discussion then focused on whether this room was about distraction or de-escalation and how that might shape the materials bought. Further questions centred on the safety aspects of having glass and other hard materials in the room.

In light of the latter part of the discussion the panel agreed to make £4,500 available from minor capacity works in partnership with the Estates Team. This was to be spent on paint, heavy furniture, privacy screening, built-in dimmer lighting, safe TV and radio and the calming items such as 'rummage and fiddle boxes'. The Director of Nursing offered to support the Matron in tying this work into a deeper understanding of the effectiveness of de-escalation to develop a new model of care on the ward. The sensory room is now complete and patients and staff are really excited about the new space and positive impact that this will have on therapeutic experience and steps to recovery.

Physical activities at a medium secure unit
Service users at the Tamarind played their part in pitches to our Dragons' Den style improvement panels. On Cedar Ward a service user was involved in creating a bid which led to a new indoor running machine in a previously unused room. Service users on Lobelia Ward asked for more sports equipment and the team have made use of an outside courtyard to develop a get active programme with service users as a result. It was a similar story for Myrtle Ward where two outdoor pieces of gym equipment are being used to complement and enhance fitness programmes.

Better wound management
The Trust's Tissue Viability Lead and Continence Advisor, along with other colleagues, proposed a sustainable approach which would see specialist wound management boxes being held on all Trust wards.

Before the introduction of the boxes staff often had to take patients who had self-harmed to A&E. This could exacerbate their condition and is costly and difficult for ward teams. On return from A&E staff sometimes have delays while wards order specialist equipment which can lead to poor care and heightened infection rates in self-harm wounds.

The boxes would provide specialist equipment such as transparent plasters, sealing strips, specialist ointment and bandages. The Tissue Viability Lead and Continence Advisor would hold the stock centrally and switch in new boxes as part of her normal duties to ensure wards had a permanent stock. The boxes will be dated and sealed to help ensure materials never become obsolete on wards that don't use them. The Tissue Viability Lead and Continence Advisor explained how a simple pathway chart would be contained in the boxes along with training on when and how to use the boxes rather than going to A&E.

Funding was agreed and a first step the boxes were trialled at the female medium secure unit and following successful evaluation of this and positive feedback from staff, it was agreed that the project would be rolled out Trust wide. This initiative has made a positive difference both for staff and service users.

Service user leave 'app'
Japonica Suite at The Oleaster are piloting a new app for safely and efficiently recording leave. The idea came forward to our Dragons' Den improvement panel who were able to add it to an existing programme of work.

The idea of the app is that it will be a quick and efficient system which will allow nursing staff to safely document when service users are using leave. The system will be used for both detained and informal service users, helping nursing staff to safely risk assess leave. It will also be a quick system to make nursing staff aware when people are due to return to a ward and will work in connection with our digital recording of patient observations.

Annex one

Birmingham and Solihull Mental Health NHS Foundation Trust
Quality Account 2018/19
Statement of Assurance from NHS Birmingham and Solihull CCG
May 2019

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 inclusion in the Trust's 2018/19 Quality Account.

1.2 A draft copy of the Quality Account was received by the CCG on 30th April 2019 and this statement has been developed from the information presented to date

1.3 The report provides key details relating to progress made in delivering the first 2 years of a 3-year Quality Strategy (2017-2020) based on 8 quality ambitions.

1.4 It was noted that positive progress had been made against each of the 5 quality priority goals.

1.5 It is commendable that the Trust achieved goal1, "develop and implement a clinically driven and consistent approach to Quality Improvement across the organisation". We are committed to engaging with the trust in a collaborative and innovative manner to support this work going forward into 2019/20.

1.6 It was positive to see that good progress had been made in delivering goals relating to suicide prevention and we note that Birmingham and the Black Country currently has the 8th lowest suicide rate in England.

1.7 We acknowledge the significant amount of work undertaken by the trust in trying to achieve the 5 quality goals however we note that a number of targets set by the Trust were not achieved, and in particular, falls and assaults and restraints.

1.8 In terms of the goals for 19/20, we very much welcome the ongoing inclusion of Recovery, Carer and Family Involvement however the trust should consider the development of an indicator. There is currently no recovery measure or outcome based metrics in place other than IAPT that enable us to see the impact of the trusts work on people's lives.

1.9 We are pleased to see that the Trust is to establish a patient safety response team who will provide more detailed investigations of serious incidents and will be able to work with clinicians to understand immediate learning and improvement opportunities. The CCG remains committed to working with the trust throughout 19/20 to bring forward improvement in the serious incident process and improve the quality of Serious Incident Investigation reports.

1.10 The CCG is pleased to note the work of the Learning from Deaths Group and the decision taken by the Trust to go beyond the minimum requirements of national guidance in terms of extending the cohort of caseload reviews. We support this work in order to aim at providing the safest services possible.

1.11 The Trust has made significant progress in reducing restraint levels and we note that 2 years into the strategy and with expert guidance from the Positive and Proactive Care Expert panel they have moved out of the upper quartile of these reportable incidents.

1.12 It was positive to note the Recovery College model has been extended to Solihull and the north of Birmingham. We further note the extension of recovery training and achieving IMPROC accreditation.

1.13 The Trust's approach to physical health has improved in some areas which is reassuring however we note that activities provided across the Trust need to increase. It is acknowledged this will be a focus of two particular quality improvement projects. We also note the 3-year physical health strategy which has been in place since August 2018.

1.14 In relation to the MHRA requirement for prescribing Valproate for Bipolar Disorder, the CCG Medicines Management team confirm that the Chair and Vice Chair of Trust's Pharmacological Therapies Committee have been proactive in trying to ensure this is addressed in a robust manner. The quality account might benefit from confirming that all clinicians have addressed this issue with their patients.

1.15 It was positive to see that the Trust had participated in 100% of both national clinical audits and national confidential enquiries it was eligible to participate in, and that actions, learning and further work were identified as a result of these programmes.

1.16 Following the CQC inspections of core services and Trust wide well led review the overall rating was "requires improvement". We thank the Trust for listing the issues arising from the inspection and look forward to receiving a copy of the Trust's action plan in response to this inspection.

1.17 As Commissioners we look forward to working collaboratively with the Trust and to further build on relationships as we move forward into 2019/20.

Paul Jennings
Chief Executive Officer
Birmingham and Solihull CCG

Statement from Healthwatch Birmingham on Birmingham and Solihull Mental Health Foundation Trust Quality Account 2018/19

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 the many initiatives the Trust has implemented over the year to improve patient care. In particular, two of these initiatives (Physical Observation App and the MERIT Programme) were winners at the 2019 Leading Healthcare Awards.

It is, however, disappointing that the Trust's CQC rating remains 'requires improvement' for the safety, effectiveness and well-led domains. Nonetheless, we are pleased the CQC has given the domains for caring and responsiveness a rating of good. We encourage the Trust to continue implementing the actions it has outlined in the Quality Account. These are important issues and reflect what Healthwatch Birmingham has heard from patients and members of the public (e.g. failures to take into account patients' multiple health concerns; difficulties getting in touch with care teams; inadequate support for patients; attitudes of healthcare professionals; delays in getting a CPN and frequent changes to the CPN; long waiting lists for appointments; issues with prescriptions; failure to get blood test or physical checks; and inaccessible procedures such as for changing care teams).

We also note that the CQC has rated the Health Exchange, one of the Trust's services, as 'inadequate'. Homelessness has been a key policy issue for Birmingham and the Health and Social Care Overview and Scrutiny Committee. Stakeholders working on homelessness in Birmingham have named the Heath Exchange as a key asset for the implementation of the city's homelessness strategy. This service is, therefore, an important support for the homeless in Birmingham and we welcome actions being taken to improve. We particularly welcome the action to 'gain feedback and explore effective ways to act on feedback in order to improve patient satisfaction'. We note that the Trust has already implemented recommended changes and the CQC has re-inspected Health Exchange. We believe one way to demonstrate the use of patient feedback would be to engage with patients to find out the impact of the changes that have been implemented and determine how well they meet their needs. However, Healthwatch Birmingham believes that having a structured process for engaging people would be ideal (i.e. through a patient and public involvement [PPI] strategy).

Patient and Public Involvement

It is evident in the Quality Account that the Trust is responsive to the needs of patients. According to the Service User Survey, there has been an improvement in how the Trust works with service users and involves families'. The Quality Account does demonstrate that the Trust uses various methods to engage with patients, service users and carers. For instance, through the 'recovery for all' training, patients and carers can articulate what recovery means to them, set goals and select the support they need. We also welcome the establishment of a Family and Carer Pathway Group, which has contributed to various activities within the Trust. We also note that the Trust is gathering feedback from spaces where seldom heard or hard to reach groups might be, such as local charities, the Somali group, and mosques. This is important to ensure that the views of the diverse population the Trust serves are heard and reflected in changes and improvement. We look forward to reading about the impact of these initiatives in the 2019/20 Quality Account.

It is positive to read how patient feedback and experiences are used in decision-making across the Trust. In particular that the Family and Carer Pathway Group has contributed to the development of a carer assessment tool, to the wording on the Trust's complaints letter, to the serious investigation letters to families, and to the review of the carers strategy. We

also note that, based on an inpatient survey and the Friends and Family Test, the Trust is planning to increase the number of activities available to inpatients (such as the outdoor gym). We welcome that the Quality Improvement Projects for 2019/20 will include activities to improve physical health indicators and subsequent care planning. We look forward to reading about the impact of this on the level of activities for inpatients in the 2019/20 Quality Account.

Regarding the Friends and Family Test (FFT) scores, we note that 90% of patients would recommend the Trust to their family and friends. On the other hand, the Staff Friends and Family Test indicates that only 53.1% would recommend the Trust as a provider of care to their family or friends. This is 36.9% lower than the patient FFT scores. We recommend that the Trust investigates this difference further and use the findings to inform service improvement. We would like to read in the 2019/20 Quality Account the actions that have been developed in response to staff feedback and involvement.

The work the Service User Engagement Team is carrying out is commendable and will help the Trust to develop the structures needed for the effective use of feedback and experiences. We note the development of a feedback tool that records all patient experiences and is in a format that enables comparison with FFT, complaints and PALs data. Also, a dashboard that is available to all Clinical Governance Committees to track trends and quantities of all feedback. We particularly welcome that the 360-degree feedback tool is continuing to enable managers to give feedback on the effectiveness of patient experience on their wards to ensure buy-in. We would have liked to read in this Quality Account how this has improved staff buy-in across the Trust in relation to the use of feedback and patient experiences.

Healthwatch Birmingham believes that having a staff team that understands the Trust's strategic approach for patient experience is important for developing a shared vision around the use of patient experience and feedback. We believe that Healthwatch Birmingham's Quality Standard for Patient and Public Involvement (PPI) has some questions that might help the Trust to develop thinking around staff buy-in.

Healthwatch Birmingham still believes that the Trust would benefit from developing a Patient Public Involvement (PPI) Strategy that would ensure a shared vision across the Trust services. We also believe that a strategy would support the achievement of one of the Trust's 2019/20 Quality Priorities: '*Promoting recovery, co-production and family, carer and service user involvement'.* We note that one of the enablers for this priority is to *'scope all opportunities (existing and future) for co-production and family, carer and service user involvement from ward to board*'. A PPI strategy would outline:

- Why the Trust is listening
- What the Trust is listening for
- How the Trust listens
- Who the Trust wants to hear from (including 'seldom-heard' groups)
- How the Trust will use what it hears
- Clear arrangements for collating feedback and experience.

Over the past year, Healthwatch Birmingham has worked with clinical commissioning groups (CCGs) and Trusts to benchmark their PPI processes using Healthwatch Birmingham's Quality Standard. We have had meetings with Birmingham and Solihull Mental Health Trust on this and recognise the work that the Trust is carrying out regarding patient experience and feedback. We hope to continue to support the Trusts PPI activities in 2019/20.

Trust Performance 2018/2019

Quality Priorities 2018/19

We are pleased that the Trust is moving in the right direction regarding suicide prevention such that the benchmarking position has improved from 9.2 suicides per 100,000 population in the first year of implementation of the strategy to 8.0 suicides per 100,000 population in the second year. We would like to see a more significant improvement in 2019/20. Equally, prone restraints have reduced by 14% on 2017 figures. This is welcome as the Trust had one of the highest levels of prone restraints in the country. We look forward to reading further improvements in the coming year. We welcome that the Trust's Positive and Proactive Care Expert Panel have undertaken work to understand the experience of exclusion and have engaged staff and patients to identify improvements. We would like to read on the impact of this in the 2019/20 Quality Account.

We note that the Trust has not achieved the goal to ensure 90% of inpatients get a cardio metabolic assessment and 75% for community patients. However, we are encouraged by the range of physical health opportunities and activities for inpatients such as an outdoor gym and the use of pedometers for all patients to measure the level of activity. We would like to read of an increase in these activities across the Trust's different services in the 2019/20 Quality Account. We also ask the Trust to consider social prescribing community patients to community-based activities such as leisure centres, local park run or walking groups.

We note that the Trust continues to face challenges in addressing falls, which have increased from two in 2017/18 to seven in 2018/19. We welcome the Trust's recognition for a new approach to addressing this issue and hence the inclusion of a qualitative measure to better understand individuals' needs. We would like to read in the 2019/20 Quality Account the impact of the use of falls champions, the use of assistive technology if implemented, and the increase of staff at times when there are more cases of falls.

Learning from Audits

We note the number of national and local clinical audits the Trust has taken part in 2018/19. We welcome that the Trust has taken the time to develop actions to address the findings of the audits reviews. We particularly welcome plans around improving the number of debriefs carried out following an episode of rapid tranquilisation, embedding the use of SafeWards to reduce violence; and activities to ensure adherence to the Mental Health Act when prescribing medication. We would like to read in the 2019/20 Quality Account, the impact of these actions on patients' safety.

Patient Experience of Community Mental Health Services

We are pleased that the Trust has a score of 7.1, which is above the national average of 6.8. We note the changes planned and would like to read in the 2019/20 Quality Account the impact of Trust-wide recovery strategy; increased publicity for the crisis line; recovery training, and distribution of Buzz guide mini directory to all services. Healthwatch Birmingham would like to request a copy of the directory for our information and signposting line. We receive calls through our information and signposting line from patients of the Trust and this would be a useful tool for us.

Patient Safety Incidents

The Trust has only reported on data from April to September 2018. We note that the total incidents reported during this time were 5233, and there were forty-four patient safety incidents per 1000 bed days, and twenty-two resulted in severe harm or death (representing 0.4%). We ask the Trust to update this data to cover the reporting period.

The Trust states that 636 patients died between April 2018 and March 2019. Thirty-eight deaths were subjected to a review and twenty-four to an investigation. Three of these deaths were identified as unavoidable and resulting from problems with care. We note the emerging themes from these three cases, which include: lack of professional curiosity in risk assessment, gaps in service due to communication in interagency working, involving family and carers in the assessment process, involving medics at an earlier point and access to out of hour's medics, and the management of cancelled appointments. We would like to read in the 2019/20 Quality Account, how these themes have been acted on and learning shared across the Trust.

National Mental Health Indicators
We are pleased that the Trust has performed above average in improving access to psychological therapies and people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral. However, it is disappointing that out of area placements for adult mental health services average bed days are increasing from 138 in 2017/18 to 566.75 in 2018/19.

PLACE Results
We are pleased that the Trust is performing above average in all categories (cleanliness; food and hydration; privacy, dignity and wellbeing; condition, appearance and maintenance; dementia (environment); and disability (environment). We note that the Trust is involved in the PLACE Assessment process review with NHS Improvement. Healthwatch Birmingham recently published a report into people's experiences in NHS Hospital waiting rooms. The focus of the report is on people's experiences of waiting times, the environment, communication, accessibility, and dignity and respect. We believe that the findings and recommendations in this report would be useful to the Trust and feed into this review. In particular, the report findings and recommendation could inform the review into the format of the paper work, the questions, and many other aspects of the assessments. The report can be found here: http://bit.ly/2H1ZKMD

The Trust's Priorities for 2019/20

Healthwatch Birmingham has taken note of the Trust's priorities for 2019/20 and these reflect the experiences people tell us. We are pleased that the priorities have been developed following consultation with senior clinicians across the Trust and the council of governors. In addition, there has also been input from patient surveys, learning from serious incidents, staff survey, patient feedback and CQC inspections. We look forward to collaborating with the Trust on these priorities over the year.

Andy Cave
CEO
Healthwatch Birmingham

Birmingham and Solihull Mental Health NHS Foundation Trust Quality Report 2018/19

"Healthwatch Solihull is delighted to have been invited to comment on the Quality Report for the Trust. We welcome the Trust's focus on listening to its service users, their families and also its staff to ensure that it can continue to improve and sustain its service provision, all of which is a constant theme running throughout the report.

In relation to the Trust priorities for improvement 2019/20 patient experience contributions are key and it is important that a range of methods are used to gather experiences, including the Friends and Family Test (FFT) and we advocate direct patient engagement is used where possible. Healthwatch also believes that real time engagement and post patient experience gathering is key.

The report format ensures that the priorities for the year ahead are identified as the ongoing programme of work. However, Healthwatch Solihull is unable to validate the priorities as they have not been involved in specific stakeholder consultation around these priorities.

Healthwatch Solihull would welcome the opportunity to work better with the trust to focus on improving patient experience and supporting the Trust in the achievement of its aims.

Healthwatch Solihull looks forward to reviewing progress against the forthcoming years priorities and to reviewing outcomes measured in the 2019/20 Quality Report to be able to assess how the quality initiatives have impacted on the residents of Solihull."

Kind Regards

Anthony Martlew
Manager Healthwatch Solihull

Overview and Scrutiny Committee

The Birmingham Health and Social Care Overview Scrutiny Committee has indicated that it is not in a position to provide a statement on Birmingham and Solihull Mental Health NHS Foundation Trust draft Quality Report 2018-19.

Statement from the Council of Governors – quality account 2018/19

Throughout 2018/19, 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.

We recognise the challenging environment in which the Trust has found itself this year. Unprecedented demand on services at times has impacted on our ability to ensure that patients are always able to access the care that they need at the point of clinical decision making and has also had an impact on staff wellbeing. We recognise however the steps that the Trust has taken to try to manage this risk including the development of new services, the opening of more inpatient beds and a growing focus on Recovery. Our staff governors have also contributed to national debates about nurse recruitment and retention and ran the first ever Mental Health Nurses Day in February 2019 which reached 2.2 million individuals.

Despite this complex environment, we are pleased to see that we have largely delivered improvements against our Quality Strategy for the second successive year. The work that has taken place to reduce suicide levels is particularly commendable and we can also see from our patient survey that patients and their families feel more involved in crisis care planning than they have in previous years. Governors have contributed their views to the development of predictive analytics within our Psychiatric Liaison services. This is just one example of how Governors have been involved in innovative practice in developing a crisis prediction tool for patients whose behaviours may escalate requiring early intervention. We are delighted to see that for the first time in many years, the Trust has not reported any suicides of inpatients. We commend the work of staff in this area and also note the environmental improvements that have been made to our wards, including more convex mirrors and the trialling of anti-ligature door top alarm systems. We note that nationally Birmingham now has the one of the lowest suicide rates per 100,000 population in the Country.

Governors continue to be concerned about the level of violence in our inpatient wards, however we note the reduction in levels since 2016-17 and are encouraged by the work of the Positive and Proactive Care Expert Panel and Operation Stonethwaite in taking forward further improvements in 2019-2020.

Levels of prone restraint have been of concern to us as we have received national benchmarking data in previous years that has shown the Trust to be a significant outlier in this area. We are encouraged to see that this year's National Benchmarking report shows that we are no longer an outlier and that we have moved out of the upper quartile for these incidents. We applaud staff for the 14% reduction that we have seen in incidents of this nature since 2016-17. We have made suggestions that additional training be delivered to carers in least restrictive practice and are pleased to note that this will be taken forward in 2019-2020.

Our work on Recovery is something that both collectively and individually governors are very passionate about. This year we have been able to co-design new services, pathways and influence strategies relating to recovery and family, carer and patient involvement. This has provided a unique and important perspective on the way that we have develop our plans and proposals ensuring that the way forward meets the needs of members and constituents.

Governors have also been involved in the development of the Family and Carer pathway which underpins so many aspects of good mental health care.

During the year, Governors have recruited to a range of posts including a new Clinical Non-Executive Director who now sits on the Integrated Quality Committee of the Trust. We have also approved the appointment of a new Chief Executive Officer noting the strong high quality ethos that she brings to the Trust in terms of both quality and experience of patient care and also that of staff. We were delighted to present a number of awards to staff at our Quality Excellence Awards Ceremony in 2018 and to take part in the shortlisting for such awards. We have seen some excellent examples of innovation and improvement. Governors were disappointed with the increase of incidents of falls this year but recognise the increased acuity and complexity of the service users presenting in our Dementia and Frailty services. We are pleased to see the list of improvements for falls for 2019 and associated quality improvement projects. On the broader aspect of physical health, we can see improvements in the recording of cardio metabolic and cardio vascular indicators and are very proud that the Trust has been pressure ulcer free for the majority of 2018-19.
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 2018/19 and the opportunities that this has brought about for service improvement, enhanced safety and quality of care. We look forward to making even more progress in 2019-2020.

Faheem Uddin
Lead Governor, April 2019

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 2018/19 and supporting guidance and detailed requirements for quality reports 2018/19
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2018 to March 2019
    - papers relating to quality reported to the board over the period April 2018 to March 2019
    - feedback from commissioners dated 16 May 2019
    - feedback from governors dated 9 May 2019
    - feedback from local Solihull Healthwatch dated 15 May 2019 and Birmingham Healthwatch dated 15 May 2019
    - feedback from overview and scrutiny committee dated 14 May 2019
    - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 19 June 2018
    - the national patient survey for community service users dated 22 November 2018
    - the national patient survey for mental health inpatients dated 30 November 2018
    - the national staff survey dated 1 February 2019
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated 17 April 2019
    - the CQC inspection report dated 4 April 2019
- 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

22 May 2019 Date……Sue Davis, Chair

22 May 2019 Date……Roisin Fallon-Williams, 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 2019 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 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 (operating as NHS Improvement) ("NHSI"):

Specified Indicators	*Specified indicators criteria - (taken from the Annual Report which included Quality Report)*
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	Indicator value noted on page 155. NHSI specific criteria (set out within the Trust's Quality Report) noted Annex four page 192.
Inappropriate out-of-area placements for adult mental health services.	Indicator value noted on page 155. NHSI specific criteria (set out within the Trust's Quality Report) noted on Annex four page 191.

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 NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the 'Detailed requirements for quality reports 2018/19' issued by NHSI. The Directors are also responsible for the conformity of the specified indicators criteria with the assessment criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19' issued by NHSI and for reporting the specified indicators in accordance with those criteria, as referred to on the pages of the Quality Report listed above.

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 2018/19';
- 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 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the 'Detailed requirements for quality reports 2018/19'; 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 consistent with the following documents:

- Board minutes for the financial year, April 2018 and up to the date of signing the limited assurance report ("the period");
- Papers relating to quality reported to the Board over the period;
- Statement of Assurance from NHS Birmingham and Solihull CCG on Birmingham and Solihull Mental Health NHS Foundation Trust Quality Account 2018/19 dated 16/05/2019;
- Feedback from the Council of Governors dated 09/05/2019;
- Statement from Healthwatch Birmingham on Birmingham and Solihull Mental Health Foundation Trust Quality Account 2018/19 dated 15/05/2019 and Statement from Healthwatch Solihull on Birmingham and Solihull Mental Health NHS Foundation Trust Quality Report 2018/19 dated 15/05/2019;
- Statement from the Birmingham Health and Social Care Overview Scrutiny Committee dated 14/05/2019;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 - Annual Customer Relations Report 2017/18 including Complaints and PALS dated 19/06/2018;
- The latest national patient surveys: Mental Health Inpatient Survey 2018, Management Report for Birmingham and Solihull Mental Health NHS Foundation Trust dated 30/11/2018 and Mental Health Community Service User Survey 2018 Management Report for Birmingham and Solihull Mental Health NHS Foundation Trust dated 22/11/2018;
- The latest national staff survey Birmingham and Solihull Mental Health NHS Foundation Trust 2018 NHS Staff Survey dated 01/02/2019;
- Care Quality Commission inspection report, CQC Birmingham and Solihull Mental Health NHS Foundation Trust Inspection report dated 04/04/2019; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 17/04/2019.

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 complied with 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 2019, 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 2018/19';
- 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 criteria set out in the FT ARM and 'Detailed requirements for quality reports 2018/19'.

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 foundations 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 2019:

- 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 2018/19';
- 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 2018/19'.

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
Cornwall Court,
19 Cornwall Street,
Birmingham,
B3 2DT

Date: 28 May 2019

The maintenance and integrity of the Birmingham and Solihull Mental Health NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

pwc

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 (the "financial statements"):

- give a true and fair view of the state of the Group's and Trust's affairs as at 31 March 2019 and of the Group's income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19.

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 2019; the Consolidated Statement of Comprehensive Income for the year then ended; the Group Statement of Cash Flows 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 2019 was planned and executed having regard to the fact that the Group's 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 key audit matters was largely unchanged.

Overview

- Overall Group materiality: £4.830 million (2018: £4.706 million) which represents 2% of total consolidated revenue.

- We conduct the audit work on the Trust financial statements and the subsidiary Summerhill Services Limited 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 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 & 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***
Risk of management override of control and the 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 2-6 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 recognition of both revenue and expenditure, or to use inappropriate assumptions in their accounting estimates. We considered the risk to be manipulation to overstate income and/or understate expenditure in order to improve the reported position. Given the incentives, we focused our work on the elements most susceptible to manipulation. We considered these to be: • Non-standard journal transactions; • Income or expenditure whose value is dependent upon estimates, including provisions and accruals; • Income from activities; and • Unrecorded liabilities.	*Non-standard journal transactions* We focused our work on the areas most susceptible to manipulation by management override, in particular: • Unusual account combinations; and • Any journals input by a new senior member of the finance team. We traced entries to appropriate supporting documentation. *Accounting estimates* We obtained an understanding of the movements for each category of provision and performed testing on a sample of these. We examined the evidence available to support unexpected movements in year and closing positions at the year-end. We agreed a sample of accruals back to supporting documentation available, and confirmed that accruals were appropriately made or estimated. *Income from Activities* For a sample of healthcare income transactions, we obtained and agreed the income received during the year to relevant supporting documentation, including signed contracts with CCGs, and confirmed the subsequent receipt of payment. We did not identify any exceptions. We used the mismatch report prepared by the Department of Health and Social Care to identify significant differences between income, expenditure, debtors and creditors reported between other NHS organisations. We then reviewed the investigative steps taken by management for differences over £300,000. We read correspondence with the counterparties, and considered the impact, if any, that the remaining uncorroborated amounts could have on the Group's financial statements and determined that there was no material impact. *Unrecorded liabilities* We performed testing on a sample of higher value payments and invoices recorded after year-end, to assess whether they were recorded in the correct period, and whether they were accrued for appropriately. *Other year-end procedures* We performed testing on revenue items in the period shortly before and after year-end, including the recognition of credit notes, to confirm that income had been appropriately accounted for, including in the correct period. Our testing did not identify any evidence of fraud or manipulation of the Group's results.

Valuation of Property, Plant & 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 a large proportion of the Group and Trust's assets within the Statement of Financial Position. PPE at 31 March 2019 was valued at £176 million for the Group.

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 Service ("DVS") using the Optimised Modern Equivalent Asset methodology, which involves a number of assumptions. The DVS provides an external independent valuer for 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 the balance, and the potential material impact of the any subsequent measurement were misstated. The specific areas of risk considered were:

- The methodology, assumptions and underlying data used by the DVS; and
- The accounting transactions resulting from the valuation, resulting in an impairment of £16 million – with £7.1 million charged to the revaluation reserve, and £8.9 million as an exceptional item on the Statement of Comprehensive Income.

We have previously tested a sample of land and building site plans and asset information held within the Trust's Estates department, used to inform the Modern Equivalent Asset basis for valuation. We have confirmed that there were no material changes to the estate within the year for the purposes of the valuation.

We have assessed the assumptions and estimates used in the development of the optimised estate and considered the reasonableness of these using our experience of the Trust's operations.

We obtained and read the relevant sections of the full valuation performed by DVS. We assessed the assumptions and 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 recorded in the Fixed Asset Register, and consequently that the accounting treatment is appropriate recorded 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.

We determined that there were no further key audit matters relating to the financial statements of the Group or the Trust's arrangements for securing economy, efficiency, and effectiveness in the use of resources to communicate in our report.

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 Trust and 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 and Trust financial statements
Overall materiality	£4.830 million (2018: £4.706 million)
How we determined it	2% of revenue (2018: 2% of revenue)
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.

For each component in the scope of our group audit, we allocated a materiality that is less than our overall group materiality. The range of materiality allocated across components was £4.830 million to £1.426 million. Certain components were audited to a local statutory audit materiality that was also less than our overall group materiality.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £242,000 (Group and Trust audit) (2018: £230,000) 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's 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's 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 2018/19 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.

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 2019 is consistent with the financial statements and has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

In light of the knowledge and understanding of the Group and the Trust and their 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 2018/19.

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 on page 30, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19, 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 Group's and 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 Group and 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.

Our audit did not consider any impact that the United Kingdom's withdrawal from the European Union may have on the Trust as the terms of withdrawal are not clear, and it is difficult to evaluate all of the potential implications on the Trust's activities, patients, suppliers and the wider economy.

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

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 2019.

We determined that there were no key audit matters or other matters to report as a result of this requirement.

Other matters on which we report by exception

We are required to report to you if:

- the statement given by the directors on page 55, 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 patients, regulators, and other stakeholders to assess the Group's and Trust's performance, business model, and strategy is materially inconsistent with our knowledge of the Group and 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 2018/19 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
28 May 2019

Birmingham and Solihull Mental Health NHS Foundation Trust

Consolidated Financial Statements

31 March 2019

Foreword to the Accounts

These accounts, for the year ended 31 March 2019, 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.

Roisin Fallon-Williams, Chief Executive
22 May 2019

Consolidated statement of comprehensive income for the year ended March 31 2019	Note	March 31 2019 £000 Pre-exceptional Items	March 31 2019 £000 Exceptional Items	March 31 2019 £000 Total	March 31 2018 £000 Pre-exceptional Items	March 31 2018 £000 Exceptional Items	March 31 2018 £000 Total
Operating income	2	247,884	-	247,884	235,333	-	235,333
Operating costs	4	(235,647)	(8,897)	(244,544)	(222,400)	4,368	(218,032)
Operating Surplus / (Deficit)		12,237	(8,897)	3,340	12,933	4,368	17,301
Finance Costs							
Finance income	7	94	-	94	46	-	46
Finance costs	8	(5,717)	-	(5,717)	(5,654)	-	(5,654)
PDC Dividend payable		(2,778)	-	(2,778)	(2,390)	-	(2,390)
Net Finance Costs		(8,401)	-	(8,401)	(7,998)	-	(7,998)
Corporation tax expense	29	(143)	-	(143)	72	-	72
Surplus / (Deficit) from Operations		3,693	(8,897)	(5,204)	5,007	4,368	9,375
Surplus / (Deficit) for the year		3,693	(8,897)	(5,204)	5,007	4,368	9,375
Other comprehensive Income / (Expense)							
Will not be reclassified to income and expenditure:							
Revaluation (losses) / gains on property, plant and equipment				(7,058)			8,686
May be reclassified to income and expenditure when certain conditions are met:							
Total comprehensive income / (Expense) for the year				(12,262)			18,061

Statement of Financial Position		Group		Trust	
	Note	**March 31 2019**	March 31 2018	**March 31 2019**	March 31 2018
As at March 31 2019		**£000**	£000	**£000**	£000
Non-current assets					
Intangible assets	9	**5,498**	4,226	**5,498**	4,226
Property, plant and equipment	10	**175,911**	190,346	**82,447**	90,985
Subsidiary investment	12	**-**	-	**25,718**	23,036
Trade and other receivables	13	**1,521**	1,512	**53,362**	49,248
Deferred tax asset	30	**-**	111	**-**	-
Total non-current assets		**182,930**	196,195	**167,025**	167,495
Current assets					
Inventories	11	**408**	358	**244**	208
Trade and other receivables	13	**14,373**	14,560	**16,332**	16,059
Non-current assets classified as held for sale	10.7	**-**	-	**-**	6,743
Cash and cash equivalents	22	**17,714**	17,415	**16,388**	16,881
Total current assets		**32,495**	32,333	**32,964**	39,891
Current liabilities					
Trade and other payables	14	**(25,290)**	(22,880)	**(23,867)**	(22,528)
Borrowings	16	**(4,335)**	(3,608)	**(5,085)**	(4,358)
Provisions for liabilities and charges	19	**(647)**	(1,262)	**(647)**	(1,262)
Other liabilities	15	**(2,805)**	(4,288)	**(3,460)**	(4,944)
Total current liabilities		**(33,077)**	(32,038)	**(33,059)**	(33,092)
Total assets less current liabilities		**182,348**	196,490	**166,930**	174,294
Non-current liabilities					
Borrowings	16	**(86,317)**	(90,060)	**(86,316)**	(90,060)
Provisions for liabilities and charges	19	**(1,720)**	(1,790)	**(1,720)**	(1,790)
Other liabilities	15	**(32)**	-	**(1,147)**	(1,803)
Total non-current liabilities		**(88,069)**	(91,850)	**(89,183)**	(93,653)
Total assets employed		**94,279**	104,640	**77,747**	80,641
Financed by (taxpayers' equity)					
Public dividend capital		**103,779**	101,878	**103,779**	101,878
Revaluation reserve		**25,117**	32,175	**1,871**	4,191
Income and expenditure reserve		**(34,617)**	(29,413)	**(27,903)**	(25,428)
Total taxpayers' equity		**94,279**	104,640	**77,747**	80,641

The accounts and the associated notes were approved by the Audit Committee, who have delegated authority from Trust Board to approve the financial statements. The financial statements were approved on 22 May 2019 and signed on its behalf by:

Signed. .....Roisin Fallon-Williams, Chief Executive

Date: 22 May 2019

Group statement of Changes in Taxpayers Equity For year ended March 31 2019	Total Taxpayers Equity £000	Public dividend capital £000	Revaluation reserve £000	income and expenditure reserve £000
Taxpayers' Equity at April 1 2018 - as previously stated	104,640	101,878	32,175	(29,413)
Prior period adjustment	-			
Taxpayers' Equity at April 1 2018	104,640	101,878	32,175	(29,413)
Surplus / (Deficit) for the year	(5,204)			(5,204)
Revaluation gains/ (losses) on property, plant and equipment	(7,058)		(7,058)	
Public Dividend Capital Received	1,901	1,901		
Transfer to retained earnings on disposal of assets	-			
Taxpayers' Equity at March 31 2019	94,279	103,779	25,117	(34,617)
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 earnings on disposal of assets	-	-	-	-
Taxpayers' Equity at March 31 2018	104,640	101,878	32,175	(29,413)

Trust statement of Changes in Taxpayers Equity For year ended March 31 2019	Total Taxpayers Equity £000	Public dividend capital £000	Revaluation reserve £000	income and expenditure reserve £000
Taxpayers' Equity at April 1 2018 - as previously stated	80,641	101,878	4,191	(25,428)
Prior period adjustment	-			
Taxpayers' Equity at April 1 2018	80,641	101,878	4,191	(25,428)
Surplus / (Deficit) for the year	(2,475)	-	-	(2,475)
Revaluation gains/ (losses) on property, plant and equipment	(2,320)	-	(2,320)	
Public Dividend Capital Received	1,901	1,901	-	
Transfer to retained earnings on disposal of assets	-	-	-	
Taxpayers' Equity at March 31 2019	77,747	103,779	1,871	(27,903)
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 earnings on disposal of assets	-	-	-	-
Taxpayers' Equity at March 31 2018	80,641	101,878	4,191	(25,428)

Group statement of cash flows For the year ended March 31 2019	Note	March 31 2019 £000	March 31 2018 £000
Cash flows from operating activites			
Operating (deficit) / surplus for the year		3,340	17,301
Depreciation and amortisation	4	6,234	5,114
Impairments	4.1	8,897	-
Reversals of impairments	4.1	-	(4,368)
Loss / (gain) on disposal		-	15
(Increase) / decrease in trade and other receivables		400	3,738
(Increase) / decrease in inventories		(51)	(10)
Increase / (decrease) in trade and other payables		2,064	1,647
Increase / (decrease) in other liabilities		(1,483)	314
Increase / (decrease) in provisions		(686)	126
Other movement in operating cash flows		-	-
Net cash generated from operating activities		18,715	23,877
Cash flows from investing activities			
Interest received	7	94	46
Purchase of intangible assets	9	(2,518)	(3,533)
Purchase of property, plant and equipment	10	(5,542)	(5,194)
Sales of property, plant and equipment		-	-
Net cash used in investing activities		(7,966)	(8,681)
Cash flows from financing activites			
Public dividend capital received		1,901	1,250
Public dividend capital repaid		-	-
Loans repaid to foundation trust financing facility		(2,183)	(2,183)
Capital element of private finance initiative obligations		(1,425)	(1,288)
Interest paid on loans from foundation trust financing facility		(1,534)	(1,628)
Interest element of private finance initiative obligations		(4,219)	(4,058)
PDC dividend paid		(2,990)	(1,025)
Net cash used in financing activities		(10,450)	(8,932)
Net increase/ (decrease) in cash and cash equivalents		299	6,264
Cash and cash equivalents at 1 April		17,415	11,151
Cash in hand (petty cash)	22	45	54
Cash at commercial banks	22	1,326	534
Cash at GBS	22	16,343	16,827
Cash and cash equivalents at 31 March		17,714	17,415

Notes to the financial statements

1 **Accounting policies and other information**

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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.

Going Concern

These accounts have been prepared on a going concern basis. After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue to operate for the foreseeable future. The Trust has for the subsequent financial year (2019/20) signed up to the NHS Provider Sustainability Fund (PSF).

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 Services Ltd (formerly known as Summerhill Supplies Limited until 28 September 2018), 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 2019. The shares held are ordinary and aggregate capital and reserves amount to £22,535k as at March 31 2019 (£20,463k as at March 31 2018). Summerhill Services Limited made a loss of £611k in the year ended March 31 2019 (2017/18: £716k).

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 a 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

Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Other Income

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 such as social security costs and the apprenticeship levy 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. Other assets including plant, machinery, IT and equipment that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or both, as this is not considered to be materially different from current value in exisitng use.

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 "Guidance on Asset Valuation" paper (interpreting the RICS UK GN on DRC formerly known as UKGN 2 and before that VIP 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 scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Foundation Trust's Statement of Financial Position

1 **Accounting policies and other information (continued)**

1.7 Intangible assets

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

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:
• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
• the Foundation Trust intends to complete the asset and sell or use it;
• the Foundation Trust has the ability to sell or use the asset;
• how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Foundation Trust to complete the development and sell or use the asset; and
• the Foundation Trust can measure reliably the expenses attributable to the asset during development.

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

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

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1 **Accounting policies and other information (continued)**

1.8 Government grants

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

1.9 Inventories

Inventories are valued at 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 all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses. The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2). For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate. Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

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 0.76%, 1.14%, 1.99% or 1.99% for 1-5 years, 6-10 years, 11-40 years and 40+ years respectively in Nominal terms (New adoption from April 01 2018 previosuly done on real terms), except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 0.29% in real terms.

Contingent liability
A contingent liability is a possible obligation that arises from the past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Foundation Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

The Foundation Trust is currently investigating 3 potential injury allowance applications; due to the nature of the injuries these applications may result in a contingent liability.

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 £0.300m which we would expect to be reimbursed through our insurance policy.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution 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 NHS Resolution on behalf of the NHS Foundation Trust is disclosed at note 19.1 but is not recognised in the NHS Foundation Trust accounts.

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 Services Ltd is liable to corporation tax charges.

Current tax is recognised at the amount expected to be paid or recovered for the period based on tax rates and laws that have been enacted or substantively enacted at the statement of financial position date.

Deferred Tax

Deferred tax is provided in full, using the liability method, on taxable temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for taxation purposes. Deferred tax is not accounted for if it arises from the initial recognition of assets or liabilities that affect neither accounting nor taxable profit other than in a business combination.

A deferred tax asset is recognised only to the extent that it is probable that future taxable profits will be available against which the temporary difference can be utilised. The amount of deferred tax provided is based on the expected manner of realisation or settlement of the carrying amount of assets and liabilities, using tax rates enacted or substantively enacted at the statement of financial position date.

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 2020.

- 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 Services 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 Services 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 Services 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 Services Limited to the value of the asset.

- Lease of Juniper Centre
  The Juniper Centre (an Inpatient mental health facility) is owned by Summerhill Services 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 Services Limited to the value of the asset.

- Lease of Reaside Clinic
  The Reaside Clinic (a medium secure mental health facility) is owned by Summerhill Services 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 Reaside Clinic would be recognised as an asset in these accounts and a creditor would be included to Summerhill Services Limited to the value of the asset.

- Lease of John Black Centre (Maple Leaf Drive)
  The John Black Centre (Maple Leaf Drive) (an older persons mental health facility) is owned by Summerhill Services 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 John Black Centre (Maple leaf Drive) would be recognised as an asset in these accounts and a creditor would be included to Summerhill Services 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 2018/19 :

•2018/19
Adoption of IFRS 9 Financial Instruments, superseding IAS 39 Financial instruments recognition and measurement.
Adoption of IFRS 15 Revenue from Contracts with Customers, superseding IAS 18 Revenue and IAS 11 Construction Contracts

Standards applicable for future years:

•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)**

	2018/19 £000	2017/18 £000
Income from activities		
Cost and volume contract income	92,915	73,242
Block contract income	128,008	137,864
Other clinical income from mandatory services	3,621	4,185
Other clinical income	1,345	3,255
Agenda for Change pay award central funding	2,524	-
Total income from activities	228,413	218,546
Other operating income		
Research and development	1,144	1,335
Education and training	9,098	8,405
Non-patient care services to other bodies	1,442	1,388
Other Income	4,005	1,885
Provider Sustainability fund (PSF) income	3,782	3,774
Profit on disposal of property, plant and equipment	-	-
Total other operating income	19,471	16,787
Total operating income	247,884	235,333

2.1 **Income from activities (by Source)**

	2018/19 £000	2017/18 £000
NHS England	74,892	71,472
Clinical commissioning groups	140,958	140,029
NHS Foundation Trusts	3,321	2,203
NHS Trusts	620	612
Local authorities	2,500	2,384
Department of Health and Social Care	2,524	-
Non NHS: other	3,598	1,846
Total Income from Activities	**228,413**	**218,546**

2.2 **Income from activities arising from mandatory services**

	2018/19 £000	2017/18 £000
Income from activities arising from mandatory services	225,416	215,552
Income from activities arising from non-mandatory services	22,468	19,781
	247,884	235,333

2.3 **Commissioner requested services**

	2018/19 £000	2017/18 £000
Income from activities arising from commissioner requested services	228,413	218,546
Income from activities arising from non-commissioner requested services	-	-
	228,413	218,546

2.4 **Overseas visitors (relating to patients charged directly by the nhs foundation trust)**

	2018/19 £000	2017/18 £000
Income recognised this year	-	-
Cash payments received in year	-	-
Amounts added to provision for impairment of receivables	-	-
Amounts written off in year	-	-
Total overseas visitor income	-	-

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, 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 Services Limited

The company Summerhill Services Limited is a wholly owned subsidiary of the Trust and currently leases the Tamarind Centre, the Ardenleigh Site, the Juniper Centre, Reaside Clinic and the John Black Centre (Maple Leaf Drive) 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 2019	Healthcare services £000	Commercial trading £000	Inter-group eliminations £000	Total £000
Total segment revenue	248,103	13,551	(13,743)	247,911
Total segment expenditure	(245,104)	(11,748)	12,281	(244,571)
Operating surplus / (deficit)	2,999	1,803	(1,462)	3,340
Net financing cost	(3,352)	(2,271)	-	(5,623)
PDC dividend payable	(2,778)	-	-	(2,778)
Taxation	-	(143)	-	(143)
Retained surplus / (deficit) before non-recurring items	(3,131)	(611)	(1,462)	(5,204)
Non-recurring items				-
Retained surplus / (deficit) after non-recurring items	(3,131)	(611)	(1,462)	(5,204)
Reportable segment assets	198,586	79,103		277,689
Eliminations	-	-	(63,702)	(63,702)
Total Assets	198,586	79,103	(63,702)	213,987
Reportable segment liabilities	(119,034)	(56,568)	-	(175,602)
Eliminations			55,894	55,894
Total liabilities	(119,034)	(56,568)	55,894	(119,708)
Net assets / (liabilities)	79,552	22,535	(7,808)	94,279

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 / (deficit)	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 / (deficit) before non-recurring items	4,420	(716)	1,304	5,008
Non-recurring items	3,406	-	961	4,367
Retained surplus / (deficit) after 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 / (liabilities)	83,101	20,464	1,075	104,640

4 **Operating Costs**

	2018/19 £000	2017/18 £000
Services from NHS Foundation Trusts	4,553	4,079
Services from NHS Trusts	917	784
Services from CCGs and NHS England	-	45
Services from other NHS bodies	186	178
Employee expenses - executive directors	970	874
Employee expenses - non-executive directors	163	163
Employee expenses - staff	180,611	170,135
Drug costs	6,033	5,836
Supplies and services - clinical (excluding drug costs)	619	438
Supplies and services - general	2,409	2,272
Establishment	2,518	2,590
Transport	1,594	1,164
Premises	19,865	19,247
Increase / (decrease) in bad debt provision	133	158
Termination benefits	-	302
Depreciation on property, plant and equipment	4,988	4,526
Amortisation on intangible assets	1,246	588
Audit Services	84	80
Other auditors' remuneration	-	-
Clinical negligence	751	578
Loss on disposal of other property, plant and equipment	-	15
Internal audit costs	89	83
Consultancy costs	637	263
Other	7,281	8,002
Total operating costs	235,647	222,400

4.1 **Exceptional Items**

	2018/19 £000	2017/18 £000
Impairments / (Reversal of impairments) of property, plant and equipment	8,897	(4,368)
Termination Benefits	-	-
Total exceptional items	8,897	(4,368)

Impairment charges for the year ended March 31 2019 of £8.9m were due to changes in market price. Reversal of impairments for the year ended March 31 2018 of £4.3m were due to changes in market price.

4.2 **Analysis of loss on disposal**

	2018/19 £000	2017/18 £000
Disposal of commissioner requested service assets	-	-
Disposal of non-commissioner requested service assets	-	15
Total loss on disposal	-	15

There were no Losses recorded on the disposal of assets in 2018/19. 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.

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 2019 was £50.6k (2017/18: £49.7k) for the Trust's annual report, £7.4k (2017/18: £7.3k) for the Trust's quality accounts, £nil (2017/18: £3k) for additional payroll controls and new models of care and £8.0k (2017/18: £8.8k) for Summerhill Services Limited totalling £66.0k (£68.8k for the year ended 31 March 2018) excluding VAT. This was the fee for an audit in accordance with the Audit Code issued by NHS Improvement in December 2014. In accordance with the Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the liability of the Trust's Auditors, PricewaterhouseCoopers LLP, is restricted to £1,000,000 in respect of liability to pay damages for losses arising as a direct result of breach of contract or negligence in respect of services provided in connection with or arising from their letter of engagement dated 22 March 2019.

4.4 **Other audit remuneration**

	2018/19 £000	2017/18 £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	-	-
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	-	-

4.5 **Arrangements containing an operating lease**

	2018/19 £000	2017/18 £000
Minimum lease payments	1,929	2,119

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 £1,390k (2017/18: £1,542k) which is included within operating costs. The leases for vehicles and equipment range from 1 to 5 years and have an annual charge of £539k (2017/18: £577k) 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 £742k (2017/18: £685k). 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, the Juniper Centre, Reaside Clinic and the John Black Centre (Maple Leaf Drive) which are owned by Summerhill Services 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**

	2018/19 £000	2017/18 £000
Not later than one year	1,670	1,796
Later than one year and not later than five years	5,021	5,368
later than five years	6,525	7,971
Total future minimum lease payments	13,216	15,135

5

Directors remuneration	2018/19 £000	2017/18 £000
Short-term benefits :		
Salary	765	688
Taxable benefits	107	97
Performance related bonuses	-	-
employer's pension contributions	98	89
Post-employment benefits :	-	-
Other long-term benefits :	-	-
Termination benefits :	-	-
Share-based payment :	-	-
Total directors remuneration	970	874

The medical director was paid £58k during the year ended March 31 2019 (£58k during year ended March 31 2018), 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)	2018/19 £000	2017/18 £000
Salaries and wages	143,168	135,148
Social security costs	14,384	13,663
Employers contribution to NHS pensions	16,490	15,783
Apprenticeship Levy	680	642
Termination benefits (see note 4 and 4.1)	-	302
Agency / contract staff	6,859	5,773
	181,581	171,311
Less: capitalised staff cost		
Total recognised in operating expenses	181,581	171,311

6.1

Average number of employees (WTE basis)	2018/19 Number	2017/18 Number
Medical	223	221
Administration and estates	846	837
Healthcare assistants and other support staff	686	644
Nursing and health visiting staff	1,198	1,186
Scientific, therapeutic and technical staff	622	603
Other	89	114
Total Average	3,664	3,605

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.

	2018/19 £000	2018/19 Number	2017/18 £000	2017/18 Number
No. of early retirements on the grounds of ill health		1		7
Value of early retirements on the grounds of ill health	37		437	

6.3 **Staff exit packages**

Exit package cost band	No. of compulsory redundancies 2018/19	No. of other agreed departures 2018/19	Total no. of exit packages by cost band 2018/19	Total no. of exit packages by cost band 2017/18
< £10,000	-	-	-	4
£10,000 - £25,000	-	-	-	2
£25,001 - £50,000	1	-	1	4
£50,001 - £100,000	1	-	1	4
£100,001 - £150,000	-	-	-	-
£150,001 - £200,000	-	-	-	-
Total number of exit packages by type	2	-	2	14
Total resource cost £000			113	450

There were no exit packages paid to senior managers during this financial year (2017/18: nil).

7 **Finance Income**

	2018/19 £000	2017/18 £000
Interest on deposits / investments	94	46

8 **Finance costs**

	2018/19 £000	2017/18 £000
Loans from the foundation trust financing facility	1,498	1,597
Finance costs in PFI obligations :		
Main finance costs	2,607	2,668
Contingent finance costs	1,612	1,389
Total finance costs	5,717	5,654

9 Intangible assets

9.1

Group and Trust Intangible assets for year ended March 31 2019	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 2018 - as previously stated	7,611	5,857	253	552	949
Prior period adjustment	-	-	-	-	-
Cost or valuation at April 1 2018	7,611	5,857	253	552	949
Additions - purchased	2,518	1,593		301	624
Disposals	-	-	-	-	-
Cost or valuation at March 31 2019	10,129	7,450	253	853	1,573
Amortisation at April 1 2018 - as previously state	3,385	2,793	253	-	339
Prior period adjustment	-	-	-	-	-
Amortisation at April 1 2018	3,385	2,793	253	-	339
Provided during the year	1,246	979	-	110	157
Reclassifications	-	-	-	-	-
Disposals	-	-	-	-	-
Amortisation at March 31 2019	4,631	3,772	253	110	496
NBV - Purchased at April 1 2018	4,226	3,064	-	552	610
NBV - Donated at April 1 2018	-	-	-	-	-
Total NBV at April 1 2018	4,226	3,064	-	552	610
NBV - Purchased at March 31 2019	5,498	3,678	-	743	1,077
NBV - Donated at March 31 2019	-	-	-	-	-
Total NBV at March 31 2019	5,498	3,678	-	743	1,077

9.2

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

10 Property plant and equipment

10.1

Group property, plant and equipment for year ended March 31 2019	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 2018 - as previously stated	209,088	17,843	165,466	-	257	2,830	84	10,473	12,135
Prior period adjustment	-	-	-	-	-	-	-	-	-
Cost or valuation at April 1 2018	209,088	17,843	165,466	-	257	2,830	84	10,473	12,135
Additions - purchased	6,509	-	1,186	-	5,323	-	-	-	-
Additions - donated	-	-	-	-	-	-	-	-	-
Acquisition through business combination	-	-	-	-	-	-	-	-	
Impairments charged to operating expenses	(8,925)	-	(8,925)	-	-	-	-	-	-
Impairments charged to the revaluation reserve	(7,646)	-	(7,646)	-	-	-	-	-	-
Reversal of impairments credited to operating expenses	28	28	-	-	-	-	-	-	-
Reversal of impairments credited to the revaluation reserve	588	588	-	-	-	-	-	-	-
Reclassifications	(1)	-	1,453	-	(3,517)	23	-	1,424	616
Revaluation surplus	-	-	-	-	-	-	-	-	-
Transfers to non-current assets classified as held for sale (note 10.7)	-	-	-	-	-	-	-	-	-
Transfers from accumulated depreciation*	(2,724)	-	(2,724)	-	-	-	-	-	-
Disposals	-	-	-	-	-	-	-	-	-
Cost or valuation at March 31 2019	196,917	18,459	148,810	-	2,063	2,853	84	11,897	12,751
Accumulated depreciation at April 1 2018 - as previously stated	18,742	-	-	-	-	2,425	84	8,272	7,961
Prior period adjustment	-	-	-	-	-	-	-	-	-
Accumulated depreciation at April 1 2018	18,742	-	-	-	-	2,425	84	8,272	7,961
Provided during the year	4,988	-	2,724	-	-	175	-	910	1,179
Acquisition through business combination	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Reversal of impairments credited to operating expenses	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluation surpluses	-	-	-	-	-	-	-	-	-
Transferred to cost or valuation*	(2,724)	-	(2,724)	-	-	-	-	-	-
Disposals	-	-	-	-	-	-	-	-	-
Accumulated depreciation at March 31 2019	21,006	-	-	-	-	2,600	84	9,182	9,140
NBV - Purchased at April 1 2018	190,346	17,843	165,466	-	257	405	-	2,201	4,174
NBV - Donated at April 1 2018	-	-	-	-	-	-	-	-	-
Total NBV at April 1 2018	190,346	17,843	165,466	-	257	405	-	2,201	4,174
NBV - Purchased at March 31 2019	175,911	18,459	148,810	-	2,063	253	-	2,715	3,611
NBV - Donated at March 31 2019	-	-	-	-	-	-	-	-	-
Total NBV at March 31 2019	175,911	18,459	148,810	-	2,063	253	-	2,715	3,611

*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 £41,337k at March 31 2019 (£44,449k at March 31 2018). Depreciation of £647k was charged on these assets in the year (£560k during the year ended March 31 2018). These assets wholly relate to PFI assets.

10 **Property plant and equipment (continued)**

10.2

Trust property, plant and equipment for year ended March 31 2019	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 2018 - as previously stated	103,616	9,865	78,136	-	257	1,934	73	10,473	2,878
Prior period adjustment	-	-	-	-	-	-	-	-	-
Cost or valuation at April 1 2018	103,616	9,865	78,136	-	257	1,934	73	10,473	2,878
Additions - purchased	5,354	-	1,186	-	4,168	-	-	-	-
Additions - donated	-	-	-	-	-	-	-	-	-
Acquisition through business combination	-	-	-	-	-	-	-	-	-
Impairments charged to operating expenses	(7,117)	-	(7,117)	-	-	-	-	-	-
Impairments charged to revaluation reserve	(2,325)	-	(2,325)	-	-	-	-	-	-
Reversal of impairments credited to revaluation reserve	5	5	-	-	-	-	-	-	-
Reversal of impairments credited to operating expenses	244	244	-	-	-	-	-	-	-
Reclassifications	-	-	1,652	-	(3,099)	23	-	1,424	-
Revaluation surplus	-	-	-	-	-	-	-	-	-
Transfers to non-current assets classified as held for sale (note 10.7)	-	-	-	-	-	-	-	-	-
Transfers from accumulated depreciation*	(1,399)	-	(1,399)	-	-	-	-	-	-
Disposals	(2,189)	(334)	(1,855)	-	-	-	-	-	-
Cost or valuation at March 31 2019	96,189	9,780	68,278	-	1,326	1,957	73	11,897	2,878
Accumulated depreciation at April 1 2018 - as previously stated	12,631	-	-	-	-	1,676	73	8,272	2,610
Prior period adjustment	-	-	-	-	-	-	-	-	-
Accumulated depreciation at April 1 2018	12,631	-	-	-	-	1,676	73	8,272	2,610
Provided during the year	2,510	-	1,399	-	-	141	-	910	60
Acquisition through business combination	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Reversal of impairments credited to operating expenses	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluation surpluses	-	-	-	-	-	-	-	-	-
Transferred to cost or valuation*	(1,399)	-	(1,399)	-	-	-	-	-	-
Disposals	-	-	-	-	-	-	-	-	-
Accumulated depreciation at March 31 2019	13,742	-	-	-	-	1,817	73	9,182	2,670
NBV - Purchased at April 1 2018	90,985	9,865	78,136	-	257	258	-	2,201	268
NBV - Donated at April 1 2018	-	-	-	-	-	-	-	-	-
Total NBV at April 1 2018	90,985	9,865	78,136	-	257	258	-	2,201	268
NBV - Purchased at March 31 2019	82,447	9,780	68,278	-	1,326	140	-	2,715	208
NBV - Donated at March 31 2019	-	-	-	-	-	-	-	-	-
Total NBV at March 31 2019	82,447	9,780	68,278	-	1,326	140	-	2,715	208

*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 £41,337k at March 31 2019 (£44,449k at March 31 2018). Depreciation of £647k was charged on these assets in the year (£560k during the year ended March 31 2018). These assets wholly relate to PFI assets.

10 **Property plant and equipment (continued)**

10.3

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.

10 **Property plant and equipment (continued)**

10.4

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.

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	1	76
Assets under construction	-	-
Plant and machinery	1	5
Transport equipment	-	-
Information technology	1	5
Furniture and fittings	1	5
Intangible Assets	1	5

The numbers stated above relate to remaining useful economic life of group assets.

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 2019 £000	March 31 2018 £000	March 31 2019 £000	March 31 2018 £000
Property, plant and equipment	-	-	-	6,743

Group assets classified as held for sale during the year ended March 31 2019 were £nil (2017/18: nil). Trust assets classified as held for sale during the year ended March 31 2019 were £nil (£6,743k for year ended March 31 2018) the items previously held for sale of Reaside Clinic were disposed of in the year to the group subsidiary company Summerhill Services Ltd.

11 **Inventories**

	Group		Trust	
	March 31 2019 £000	March 31 2018 £000	March 31 2019 £000	March 31 2018 £000
Drugs	369	333	205	183
Consumables	39	25	39	25
Total Inventories	408	358	244	208

11.1 **Inventories recognised in expenses**

	March 31 2019 £000	March 31 2018 £000
Inventories recognised in expenses	6,046	4,199
Write-down of inventories recognised as an expense	12	20
Reversals of any write down of inventories	-	-
Total inventories recognised in expenses	6,058	4,219

12 **Subsidiary investment**

	Group		Trust	
	March 31 2019 £000	March 31 2018 £000	March 31 2019 £000	March 31 2018 £000
Shares in group undertakings	-	-	25,718	23,036
Total Subsidiary investment	-	-	25,718	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 2019.

Summerhill Services 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 £25,717,626 (2017/18: £23,036,225). The current purpose of the company is to own, and provide a managed lease service for Tamarind Centre, Ardenleigh Site, Juniper Centre, Reaside Clinic and the John Black Centre (Maple Leaf Drive) to the Trust, and also provide a outpatient dispensing service to the Trust which commenced in September 2013. The company decided to change its name from Summerhill Supplies Limited to Summerhill Services Limited on 28th September 2018.

13

Group trade and other receivables	Total March 31 2019 £000	Financial assets March 31 2019 £000	Non-financial assets March 31 2019 £000	Total March 31 2018 £000	Financial assets March 31 2018 £000	Non-financial assets March 31 2018 £000
Current						
Contract Receivable **	9,867	9,867	-	-	-	-
NHS receivables **	-	-	-	10,552	10,552	-
Other receivables with related parties	-	-	-	-	-	-
Provision for Impaired Contract Receivables **	(269)	(269)	-	-	-	-
Provision for impaired receivables **	-	-	-	(257)	(257)	-
Prepayments	2,476	-	2,476	2,106	-	2,106
PDC receivable	426	426	-	213	213	-
VAT Receivable	1,165	1,165	-	-	-	-
Other receivables	708	708	-	1,946	1,946	-
Total current trade and other receivables	14,373	11,897	2,476	14,560	12,454	2,106
Non-current						
Prepayments - Lifecycle replacement	1,521	-	1,521	1,512	-	1,512
Total non-current trade and other receivables	1,521	-	1,521	1,512	-	1,512

13.1

Trust trade and other receivables	Total March 31 2019 £000	Financial assets March 31 2019 £000	Non-financial assets March 31 2019 £000	Total March 31 2018 £000	Financial assets March 31 2018 £000	Non-financial assets March 31 2018 £000
Current						
Contract Receivable **	9,867	9,867	-	-	-	-
NHS receivables **	-	-	-	10,552	10,552	-
Other receivables with related parties	-	-	-	-	-	-
Provision for Impaired Contract Receivables **	(269)	(269)	-	-	-	-
Provision for impaired receivables **	-	-	-	(257)	(257)	-
Prepayments	2,417	-	2,417	2,106	-	2,106
PDC receivable	426	426	-	213	213	-
VAT Receivable	1,165	1,165	-	-	-	-
Other receivables	708	708	-	1,624	1,624	-
Loan assets*	2,018	2,018	-	1,821	1,821	-
Total current trade and other receivables	16,332	13,915	2,417	16,059	13,953	2,106
Non-current						
Prepayments - Lifecycle replacement	1,521	-	1,521	1,512	-	1,512
Loan assets*	51,841	51,841	-	47,736	47,736	-
Total non-current trade and other receivables	53,362	51,841	1,521	49,248	47,736	1,512

*Loan assets are comprised solely of loans made to the 100% owned subsidiary Summerhill Services Limited. The term of these loans is 25 years.

** Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

13 **Trade and other receivables (continued)**

13.2 **Provision for impairment of receivables 2018/19 - group and trust**

	2018/19 £000 Contract Receivables and Contract Assets	2018/19 £000 All Other Receivables
Provision as at April 1 2018 - Bought Forward	-	257
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	257	(257)
New Provision amounts arising	133	-
Utilisation of Provision (where receivable is written off)	(121)	-
Provision as at March 31 2019	269	-

13.2 **Provision for impairment of receivables 2017/18- group and trust**

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	2017/18 £000
At April 1	227
Increase in provision	158
Amounts utilised	(128)
Unused amounts reversed	-
At March 31	257

13.3 **Analysis of impaired receivables - group and trust**

	March 31 2019 £000	March 31 2018 £000
Ageing of impaired receivables:		
0-30 Days	-	37
31-60 Days	-	4
61-90 Days	-	1
Over 90 Days	269	215
Total impaired receivables	269	257

13.4 **Ageing of non-impaired receivables - group and trust**

	March 31 2019 £000	March 31 2018 £000
Ageing of non-Impaired Receivables		
0-30 Days	2,874	2,182
31-60 Days	771	1,567
61-90 Days	335	196
Over 90 Days	2,321	1,324
Total non-impaired receivables	6,301	5,269

14 **Group trade and other payables**

	Total March 31 2019 £000	Financial liabilities March 31 2019 £000	Non-financial liabilities March 31 2019 £000	Total March 31 2018 £000	Financial liabilities March 31 2018 £000	Non-financial liabilities March 31 2018 £000
Current						
NHS payables	11,269	11,269	-	2,997	2,997	-
Amounts due to other related parties	-	-	-	-	-	-
Trade payables - capital	1,762	1,762	-	786	786	-
Social security and taxes payable	3,876	-	3,876	3,637	-	3,637
Other payables	2,941	2,941	-	7,552	7,552	-
Accruals *	5,442	5,442	-	7,908	7,908	-
Total current trade and other payables	25,290	21,414	3,876	22,880	19,243	3,637

14.1 **Trust trade and other payables**

	Total March 31 2019 £000	Financial liabilities March 31 2019 £000	Non-financial liabilities March 31 2019 £000	Total March 31 2018 £000	Financial liabilities March 31 2018 £000	Non-financial liabilities March 31 2018 £000
Current						
NHS payables	9,161	9,161	-	2,997	2,997	-
Amounts due to other related parties	-	-	-	-	-	-
Trade payables - capital	1,488	1,488	-	759	759	-
Social security and taxes payable	3,824	-	3,824	3,637	-	3,637
Other payables	2,912	2,912	-	6,569	6,569	-
Accruals *	6,482	6,482	-	8,566	8,566	-
Total current trade and other payables	23,867	20,043	3,824	22,528	18,891	3,637

Other payables above includes £1,387k at March 31 2019 in respect of outstanding Employer Pension Contributions (£1,328k at March 2018).

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 16. IFRS 9 is applied without restatement therefore comparatives have not been restated.

15 **Other Liabilities - Group**

	March 31 2019 £000	March 31 2018 £000
Current		
Deferred Income	2,805	4,288
Total current other Liabilities	2,805	4,288
Non-current		
Deferred Tax Liability	32	-
Total non-current other Liabilities	32	-

15.1 **Other Liabilities - Trust**

	March 31 2019 £000	March 31 2018 £000
Current		
Deferred Income	2,804	4,288
Deferred gain on disposal	656	656
Total current other Liabilities	3,460	4,944
Non-current		
Deferred gain on disposal	1,147	1,803
Total non-current other Liabilities	1,147	1,803

16 **Borrowings - Group and Trust**

	March 31 2019 £000	March 31 2018 £000
Current		
Loans from foundation trust financing facility	2,774	2,183
Obligations under private finance initiative contracts	1,561	1,425
Total current borrowings	4,335	3,608
Non-current		
Loans from foundation trust financing facility	33,872	36,054
Obligations under private finance initiative contracts	52,445	54,006
Total Non-current borrowings	86,317	90,060

16.1 **Borrowings - Trust**

	March 31 2019 £000	March 31 2018 £000
Current		
Loans from foundation trust financing facility	2,774	2,183
Obligations under private finance initiative contracts	1,561	1,425
Loans from Subsidiary Company	750	750
Total current borrowings	5,085	4,358
Non-current		
Loans from foundation trust financing facility	33,872	36,054
Obligations under private finance initiative contracts	52,444	54,006
Total Non-current borrowings	86,316	90,060

16.2 **Reconiliation of liabilities arising from financing activities - Group**

	Total £000	DHSC Loans £000	Other Loans £000	PFI Schemes £000
Carrying Value at April 1 2018	93,668	38,237	-	55,431
Impact of implementing IFRS 9 on 1 April 2018	627	627	-	-
Cash Movements:				
Financing cash flows - principal	(3,608)	(2,183)	-	(1,425)
Financing cash flows - interest	(4,141)	(1,534)	-	(2,607)
Non-Cash Movements:				
Interest charge arising in year (application of effective interest rate)	4,105	1,498	-	2,607
Carrying Value at March 31 2019	90,651	36,645	-	54,006

16.3 **Reconiliation of liabilities arising from financing activities - Trust**

	Total £000	DHSC Loans £000	Other Loans £000	PFI Schemes £000
Carrying Value at April 1 2018	94,418	38,237	750	55,431
Impact of implementing IFRS 9 on 1 April 2018	627	627	-	-
Cash Movements:				
Financing cash flows - principal	(3,608)	(2,183)	-	(1,425)
Financing cash flows - interest	(4,154)	(1,534)	(13)	(2,607)
Non-Cash Movements:				
Interest charge arising in year (application of effective interest rate)	4,118	1,498	13	2,607
Carrying Value at March 31 2019	91,401	36,645	750	54,006

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 2019 £000	March 31 2018 £000
Gross PFI liabilities of which liabilities are due:		
- Not later than one year;	4,102	4,032
- Later than one year and not later than five years;	16,184	16,155
- Later than five years.	69,814	73,946
Finance charges allocated to future periods	(36,094)	(38,702)
Net PFI Liabilites	54,006	55,431
- Not later than one year;	1,561	1,425
- Later than one year and not later than five years;	6,758	6,426
- Later than five years.	45,687	47,580
Total PFI obligations	54,006	55,431

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 2019 Total £000	March 31 2019 PFI 1 £000	March 31 2019 PFI 2 £000	March 31 2018 Total £000
16th to 20th years (inclusive)	3,712	3,712	-	3,600
26th to 30th years (inclusive)	7,673	-	7,673	7,847

18.2

PFI total commitments (on SOFP) - group and trust	March 31 2019 £000	March 31 2018 £000
- Not later than one year;	11,384	11,087
- Later than one year and not later than five years;	48,456	47,189
- Later than five years.	319,604	331,822
Total commitments in respect of the PFI	379,444	390,098
- Not later than one year;	10,822	10,540
- Later than one year and not later than five years;	40,647	39,591
- Later than five years.	159,775	162,037
Total present value of commitments	211,244	212,168

18.3

PFI service commitments (on SOFP) - group and tru	March 31 2019 £000	March 31 2018 £000
Charge in respect of the service element of the PFI for the period	4,010	3,905
Commitments in respect of the service element of the PFI:		
- Not later than one year;	4,008	3,874
- Later than one year and not later than five years;	15,280	14,807
- Later than five years.	65,788	66,502
	85,076	85,183

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 2018	3,052	245	1,079	130	1,098	500
Arising during the year	152	150	-	-	2	-
Utilised during the year	(478)	(52)	-	(113)	(71)	(242)
Reversed unused	(359)	(140)	(167)	(17)	-	(35)
At March 31 2019	2,367	203	912	-	1,029	223
Expected timing of cash flows:						
- Not later than one year;	647	203	151	-	70	223
- Later than one year and not later than five years;	685	-	405	-	280	-
- Later than five years.	1,035	-	356	-	679	-
Total provisions for liabilities and charges	2,367	203	912	-	1,029	223

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 £63k 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 2019 (£73k at March 31 2018).

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. These amounts were 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 and the Trust is currently in legal discussions re a trademark infringement. The judgement was issued in January 2019, with costs paid during 2018/19 of £42k. The Trust were asked to provide further information to the Court as to whether any 'profit' had been made from using their trademark, and we await a final judgement on this element. The Trust has a provision of £63k for this.

19.1 **Clinical Negligence liabilities - group and trust**

	March 31 2019	March 31 2018
	£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	1,143	1,877

20 **Contractual capital commitments - group and trust**

The Group was contractually committed to £1,195k at 31 March 2019 (£262k at 31 March 2018) of capital expenditure for the purchase of property, plant and equipment.

21 **Third party assets**

The trust held £1,066k cash and cash equivalents at March 31 2019 (£1,078k March 31 2018) 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	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
At April 1	17,415	11,151	16,881	9,115
Net change in year	299	6,264	(493)	7,766
At March 31	17,714	17,415	16,388	16,881
Broken down into:				
Cash in hand (petty cash)	45	54	45	54
Cash at commercial banks	1,326	534	-	-
Cash at GBS	16,343	16,827	16,343	16,827
Cash and cash equivalents as in SOFP	17,714	17,415	16,388	16,881
Bank overdraft				
Cash and cash equivalents as in SOCF	17,714	17,415	16,388	16,881

23 **Ultimate parent compnay**

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	
	2018/19	2017/18
	£000	£000
University Hospital Birmingham NHS Foundation Trust*	3,021	2,017
NHS Birmingham and Solihull CCG **	137,943	-
NHS Birmingham Cross City CCG **	-	118,810
NHS England	78,188	73,716
NHS Solihull CCG **	-	16,560
Health Education England	8,810	8,132
Heart of England NHS Foundation Trust*	-	1,674
Solihull Metropolitan Borough Council	2,612	2,601
Birmingham Women's and Children's Hospital NHS Foundation Trust	1,634	483
Department of Health and Social Care	3,169	686

* Heart of England NHS FT is now a part of University Hospital Birmingham NHS FT as at April 01 2018
** New merged organisation comprises of previous organisations NHS Birmingham Cross City CCG, NHS Solihull CCG and NHS Birmingham South and Central CCG as at April 01 2018.

	Expenditure > £1.5m	
	2018/19	2017/18
	£000	£000
Birmingham Community Healthcare NHS Trust	3,459	3,275
NHS Pension Scheme	16,490	15,783
HMRC - Other Taxes and NI	15,207	14,232

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 2019	March 31 2018
	£000	£000
NHS England	3,467	3,995
HMRC (VAT)	1,165	1,034
Heart of England NHS Foundation Trust *	-	542
University Hospital Birmingham NHS Foundation Trust *	528	719
NHS Birmingham Cross City CCG	-	1,280
Birmingham Women's and Children's Hospital NHS Foundation Trust	1,933	529
NHS Birmingham and Solihull CCG **	207	-

* Heart of England NHS FT is now a part of University Hospital Birmingham NHS FT as at April 01 2018
** New merged organisation comprises of previous organisations NHS Birmingham Cross City CCG, NHS Solihull CCG and NHS Birmingham South and Central CCG as at April 01 2018.

	Payables > £0.5m	
	March 31 2019	March 31 2018
	£000	£000
NHS England	1,375	973
HMRC - Other Taxes and NI	3,876	3,637
NHS Pension Scheme	2,268	2,173
Sandwell and West Birmingham Hospitals NHS Trust	611	378

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 2019 the Trust was owed £129k (£91k at March 31 2018) from the Charity for expenses incurred by the Trust related to the Charity.

The Foundation Trust is parent of the wholly owned subsidiary Summerhill Services Limited. At March 31 2019 the Trust was owed £53,860k from the company (£49,557K at 31 March 2018) . Income from Summerhill Services Limited during the year amounted to £13,523k (£11,196k at 31 March 2018) and the expenditure incurred was £14,135k (£11,912k at 31 March 2018).

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
	Labour Party	Member
	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 (Left Trust on 29 March 2019)	*Ramsey Systems	*Daughter Employee
Roisin Fallon-Williams (Appointed 1 March 2019)	NIL	NIL
Brendan Hayes	NIL	NIL
Dr Hilary Grant	*BSMHFT	*Son working on Trust Bank Admin
	*BSMHFT	*Husband Working as principal clinical psychologist at meriden Programme
Sue Hartley	NIL	NIL
Dave Tomlinson	DEAT Consulting Limited which has previously provided services to the NHS	95% Shareholder and Director
	Summerhill Services Limited	Director
Charlotte Bailey	CGI Digital	Digital Technology Compnay
Linda Cullen (Appointed 1 January 2019)	CQC	Second Opionion Appointed Doctor
	Locum Child and Adolescent Consultant Psychiatrist	HTT CAMHS, Post due to end 4th April 2019
Barry Henley	King David Religious Education Fund	Charity Trustee
	Birmingham Jewish Community Care	Chair of Charity Trustees
Joy Warmington	BRAP	Chief Executive Officer
Dr Nerys Williams (Left the Trust 30 November 2018)	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	Walsall Alliance Limited	Managing Director
	Strategic Police and Crime Board - West Midlands Police and Crime Commissioner	Non Executive Director
	Cabinet Office	Member of the Community and Voluntary Services Honours Committee
	Midlands Air Ambulance Charity	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	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

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 2019 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 2019 Loans and receivables £000	March 31 2018 Loans and receivables £000
Assets as per SOFP		
Trade and other receivables excluding non-financial assets	11,897	12,454
Cash and cash equivalents (at bank and in hand)	17,714	17,415
Total group financial assets at March 31	29,611	29,869

25.1 **Trust financial assets by category**

	March 31 2019 Loans and receivables £000	March 31 2018 Loans and receivables £000
Assets as per SOFP		
Trade and other receivables excluding non-financial assets	13,915	13,953
Cash and cash equivalents (at bank and in hand)	16,388	16,881
Total trust financial assets at March 31	30,303	30,834

26 **Group financial liabilities by category**

	March 31 2019 Other financial liabilities £000	March 31 2018 Other financial liabilities £000
Liabilities as per SOFP		
Borrowings excluding finance lease and PFI liabilities	36,646	38,237
Obligations under private finance initiative contracts	54,006	55,431
Trade and other payables excluding non-financial liability	21,414	19,243
Total group financial liabilities at March 31	112,066	112,911

26.1 **Trust financial liabilities by category**

	March 31 2019 Other financial liabilities £000	March 31 2018 Other financial liabilities £000
Liabilities as per SOFP		
Borrowings excluding finance lease and PFI liabilities	37,396	38,987
Obligations under private finance initiative contracts	54,005	55,431
Trade and other payables excluding non-financial liability	20,043	18,891
Total trust financial liabilities at March 31	111,444	113,309

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 203 cases of losses and special payments totalling £259k during the year to March 31 2019 (67 cases totalling £133k during the year to March 31 2018). These amounts are reported on an accruals basis but excluding provisions for future losses.

Losses and special payments (approved cases only)	2018/19 Total No. of cases Number	2018/19 Total value of cases £000	2017/18 Total no. of cases Number	2017/18 Total value of cases £000
Losses:				
Losses of cash due to :				
Theft, fraud etc	5	1	6	1
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned in relation to :				
Other	145	121	22	28
Damage to buildings, property etc. (including stores losses) due to:				
Theft, fraud etc	-	-	-	-
Store losses	1	12	1	18
Other	-	-	-	-
Total Losses	151	134	29	47
Special payments :				
Compensation under legal obligation	14	122	16	77
Ex gratia payments; in respect of; loss of personal effects	38	3	22	9
Total special payments	52	125	38	86
Total losses and special payments	203	259	67	133

28 **Pensions**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

29

Corporation Tax Expense	2018/19 £000	2017/18 £000
UK corporation tax expense	-	-
Adjustment in respect of prior years	-	-
Current tax expense	-	-
Origination and reversal of temporary differences	143	(72)
Deferred tax expense	143	(72)
Total income tax expense in statement of comprehensive income	143	(72)
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	2018/19 £000	2017/18 £000
Deferred tax asset to be recovered after > 12 months	-	111
Deferred tax liability to be recovered after > 12 months	32	-
Total deferred tax asset / Liability	32	111

31

Initial Application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £627K, and Accruals correspondingly reduced.

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Initial Application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018). There was no material impact on these accounts from the adoption of IFRS 15.

Glossary

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

Key

Noted	Meaning
"k"	'000
" £ m"	'000,000
" '000 "	'000

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