NHS
Dudley Integrated Health and Care
NHS Trust

Annual Report

2020/21

01 Chair and Chief Executive's Foreword

When the history of the NHS is next written, 2020/21 will be recorded to have been a year like no other – the year the NHS and its partners worked tirelessly to combat the impact of the COVID-19 Pandemic.

Somewhere within the small print of history will be recorded that 2020/21 saw the establishment here in Dudley of the first NHS Trust created with the specific purpose of leading the integration of care in our community.

It is therefore with enormous pride that Dudley Integrated Health and Care NHS Trust presents its first Annual Report. This important document summarises our successes, achievements and challenges during our first twelve months of operation. It also sets out some of our hopes and aspirations for the future, as we spearhead the new national vision of integrated care in towns and boroughs like Dudley, which are at the absolute core of health and social care for our nation.

DIHC was formed on 1st April 2020 to provide an integrated care model in Dudley that provides community services which are 'wrapped around primary care' and to deliver a wide range of local services to:

- care for people in their own homes;
- improve the health and well-being of the whole population in Dudley; and
- avoid unnecessary admissions to hospital.

We believe that we have made great strides towards these goals in the past 12 months.

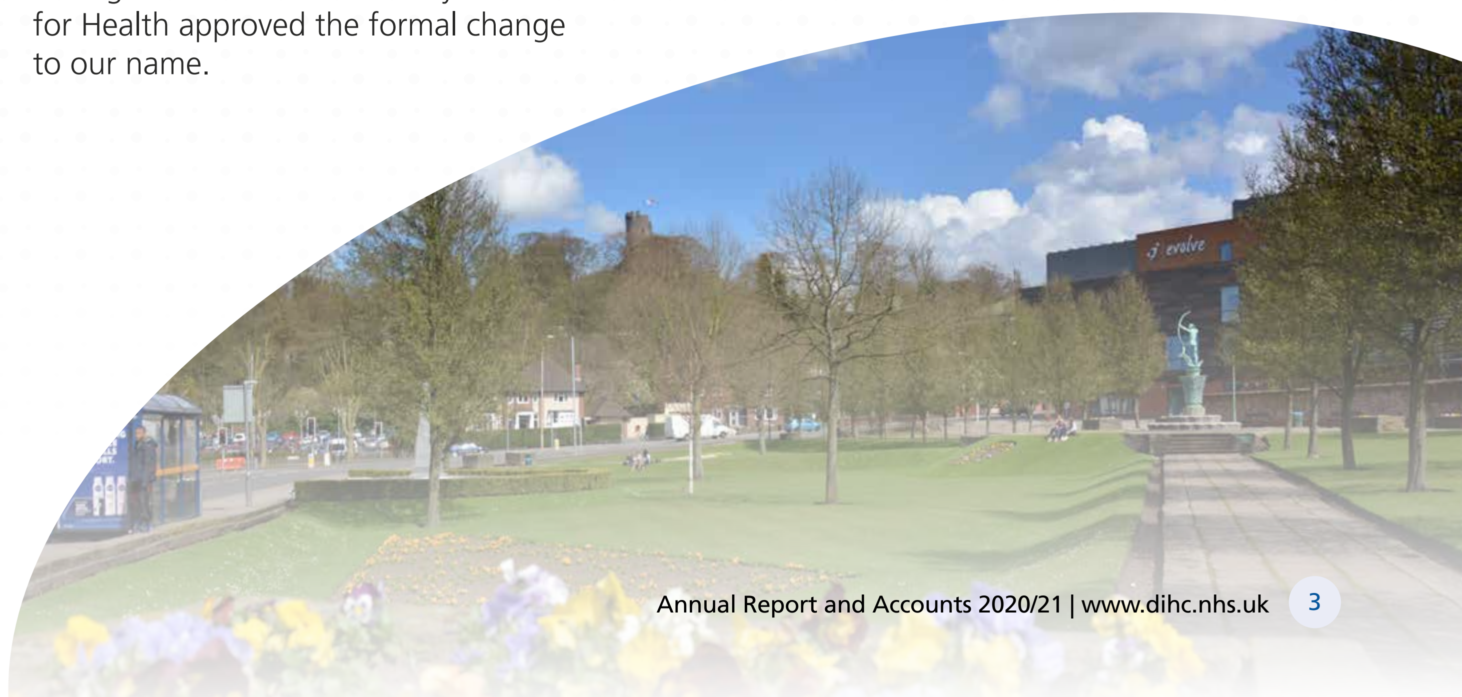
We were created in April 2020, through the re-designation of a former local NHS body Dudley and Walsall Mental Health Partnership NHS Trust (DWMH) and have inherited some of their services *(the others transferring to the newly established Black Country Healthcare NHS FT)*. We formally changed the Trust's name to Dudley Integrated Health and Care NHS Trust (DIHC) on 1st August 2020, following approval by the Secretary of State.

Our establishment during the early stages of the COVID-19 pandemic, enabled us to focus on establishing our new organisation and at the same time to focus our efforts to support the Black Country and West Birmingham system's co-ordinated response to the pandemic.

No one could have realistically foreseen what 2020/21 would bring but we are immensely proud of the part we have played in the local health and care system's response to the pandemic and throughout the period, our Trust has continued to grow in stature and influence. There have been some outstanding moments in our inaugural year but, as with the rest of the NHS, our focus and our priority in 2020/21 has been to support our service users and our staff through the challenges of COVID-19.

Despite the pandemic, 2020/21 was a year of significant achievement for DIHC.

- In April 2020 - We started the year with two mental health services, Dudley Primary Care Mental Health Service and the Dudley Talking Therapy Services (IAPT services). They were supported by a small but committed management team.
- In April 2020, three working days after we had come into existence, we started seeing COVID-likely patients on behalf of all Dudley GPs at the Pensnett Respiratory Assessment Centre.
- In August 2020 - The Secretary of State for Health approved the formal change to our name.
- In October 2020 – we expanded our service portfolio significantly through the transfer into DIHC of:
  - The Dudley Continuing Health Care and Intermediate Healthcare Commissioning functions from Dudley CCG.
  - The Dudley Pharmaceutical Public Health Team from Dudley CCG.
  - The award to DIHC by Dudley CCG of an Alternative Provider Medical Services (APMS) primary care contract for High Oak Surgery – amongst the first integrated healthcare providers to hold a direct contract.
  - Numerous additional corporate staff and services from Dudley CCG.
- During October 2020 we signed ground-breaking Primary Care Integration Agreements (binding local GP practices to observe common outcomes-based care objectives and goals) with 40 out of 43 local GP practices.
- Between October 2020 and March 2021, we recruited a cohort of Primary Care based staff (including first contact practitioners, dietitians and podiatrists) on behalf of the six Dudley Primary Care Networks (PCNs).
- We have created sound systems of governance during the year and have achieved financial balance for the period.



A cornerstone of our work during 2020/21 and a key foundation upon which we intend to build in the future is our excellent relationship with our primary care colleagues and Primary Care Network Clinical Directors in Dudley. The operating and governance models developed by DIHC are built around our relationship with primary care. Our clinical vision has been co-developed with primary care colleagues and provides an out of hospital model with DIHC's services fully integrated with primary care. We have developed a detailed legal integration agreement with primary care and 40 practices have signed the integration agreement with DIHC.

During the year our Board made a commitment to the Net Zero NHS Ambition, recognising the strategic importance of the sustainability agenda and outlining a holistic range of activities to limit the social, economic and environmental impact of our services and activities as we grow.

As a community focused provider, DIHC's workforce is, by some distance, our greatest resource. The well-being of our small but dedicated team, throughout COVID-19 and beyond is of paramount importance to our Trust and whilst only two of our services were able to take part in the National Staff Survey during 2020/21 for technical reasons, results do show that staff engagement has remained a high priority, despite the pandemic.

We have undertaken further local staff surveys during the year and these have provided great assurance of the quality of staff engagement during the various transfers from other NHS organisations to DIHC. These have also helpfully highlighted some areas for ongoing improvement and opportunities for service transformation. The link between an engaged workforce and the delivery of high-quality services is well proven and this will continue to be a key element of our future workforce strategy. We believe in and have demonstrated, early engagement with colleagues being transferred into our organisation and further, that service transformation should be led by the staff providing those services. These will continue to be key planks of our approach for the future.

We are very proud of how our staff faced into the challenges of the COVID-19 pandemic. They adapted rapidly and enthusiastically to new ways of working and facilitating change at pace, whilst keeping each other and our service-users safe. To support our staff, we have built upon our staff health and wellbeing offer - to provide wide ranging support accessible to all staff in the organisation. We saw a vaccination uptake of 89% amongst our staff, which gives us confidence in the commitment of our workforce to protect themselves and the communities we serve.

We have observed that the experience of the COVID-19 pandemic has not been a uniform one, with differences apparent in the experiences of various communities and groups laying bare the significant inequalities of opportunity and experiences that exist in our wider society. DIHC is fully committed to creating a fairer and more equitable society both for the populations we serve and in particular, for the people we employ. We will continue to work during 2021/22 and beyond to improve the equality, diversity and inclusion of our workforce.

Finally, during 2020/21 DIHC welcomed the publication of the Government's White Paper, in January 2021, titled *"Integration and Innovation – working together to improve health and social care for all"*. This policy document underscores the importance of organisations like DIHC in delivering the national vision for integrated care and we are working hard, with system partners, to develop an integrated care partnership in Dudley which puts the local citizen at the centre of our coordinated care effort.

A Dudley ICP Partnership Board is already in place across the 'Dudley place' and this will develop into the Integrated Care Partnership Board. DIHC are jointly leading this development with colleagues.

As we now look forward, our COVID-19 pandemic experience will inevitably continue to dominate our focus for the year ahead. We know that 2021/22 will bring much learning, opportunity and change and we are committed to learn from our experiences of the pandemic; to reap the benefits of our learning across our services and within our unique and different local communities. It is exciting to contemplate that 2021/22 will see us further grow our organisation into a substantial provider of health and care services in Dudley.

As a truly integrated Trust we have a great opportunity to reimagine primary care health and community-based services for Dudley, leading the way as a whole life integrated provider based on the principle of *community first, hospital when necessary*. We have during 2020/21 built sound foundations. We look forward to the future with excitement and confidence.

The Board would like to thank everyone who has worked for the Trust over the past year for their continued and unprecedented commitment to delivering high quality services for the people of Dudley.

Harry Turner
Chair

Paul Assinder
Chief Executive Officer

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03 Performance Report

This Performance Report has two parts, a **Performance Overview** and a **Performance Analysis**.

Performance Overview

The purpose of the Performance Overview is to provide key information about the Trust, our main objectives and strategies, and the principal risks that we face. We have set this overview information out under the following headings:

- Our Trust, Our Staff and Our Services
- Our Aim, Purpose and Commitments
- Our Key Achievements in 2020/21
- Performance Against Our Objectives
- Our Key Risks and Issues
- Impact of COVID-19

More detail on our performance can be found in the Performance Analysis section of this Performance Report.

Our Trust, Our Staff and Our Services

Our Trust

Dudley Integrated Health and Care NHS Trust was formed in 2020 to provide an integrated care model in Dudley. We have just completed our first year in existence.

We were effectively 'created' on 1st April 2020 when the majority of services were transferred out of Dudley and Walsall Mental Health Partnership NHS Trust into an enlarged local Trust, Black Country Healthcare NHS Foundation Trust. The residual Dudley and Walsall Mental Health Partnership NHS Trust continued in existence, and was immediately re-designated as Dudley Integrated Health and Care, with the change in name subsequently formalised by an amendment to the Trust's Establishment Order on 1st August 2020.

Initially our service offerings were very limited. We continued to provide the Primary Care Mental Health and Dudley Talking Therapy Services (IAPT services) previously provided by Dudley and Walsall Mental Health Partnership NHS Trust (DWMH), as well as running the primary care Respiratory Assessment Centre in Dudley which was established in April 2020 as a community centred response to COVID-19.

From these humble beginnings, we have grown our staff base and service offerings during 2020/21 through recruitment and through service transfers into the Trust.

- In October 2020, a cohort of corporate staff and clinical services previously provided by Dudley CCG (including Pharmaceutical Public Health Team, Intermediate Care Team, and Continuing Care Team) transferred into DIHC.
- In October 2020, Dudley CCG awarded us an Alternative Provider Medical Services (APMS) primary care contract for High Oak Surgery.
- During the last six months of 2020/21, we recruited a cohort of Primary Care based staff to provide services to the six Dudley Primary Care Networks (PCNs).

Despite this growth, we remain a small Trust, employing fewer than 230 staff at 31st March 2021, and with a turnover of only £10.9m in 2020/21. Our key metrics for 2020/21 are summarised below.

2020/21 Statistics

The Trust serves

328,093[1] people

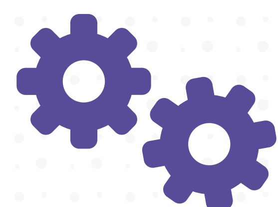
1 Dudley CCG registered population (Mar 2021) https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/march-2021

Total Employees (31st March 2021)

221

Number of Sites

3



Number of Main Commissioners

2

Total Income (£000's)

£10,888

CCG Income from patient care activities (£000's)

£7,215

Other Patient Care Income (£000's)

£938

Income from non-healthcare sources (£000's)

£2,735

As a redesignated Trust, we have prepared this report and accounts as a continuation of Dudley and Walsall Mental Health Partnership NHS Trust, but have omitted to display trend information from previous years within our Performance Report as this information is not comparable to our current operations.

We look forward to further growth and development in 2021/22 as we pursue the award of an Integrated Care Provider contract. This contract will see us responsible (through a mixture of indirect subcontracting and direct service provision) for a wide range of non-acute services across the Borough including community services, children's services, some primary care services, and a cohort of existing mental health services. We took on the provision of the Dudley School Nursing Service on 1st April 2021, the Pharmaceutical Public Health team on 1st July 2021, and we expect to see further service transfers in future to coincide with the contract award date.

Our Staff

At 31st March 2021, we employed 221 staff from across a broad spectrum of specialisms and backgrounds. Some of these staff were previously employed by Dudley and Walsall Mental Health Partnership NHS Trust, whilst others transferred in to DIHC on 1st October 2020 from Dudley CCG or from the private company which previously ran High Oak Surgery. We made every effort to welcome and support every member of transferring staff through a programme of cultural integration both pre, during and post transfer.

During 2020/21 we recruited a cohort of 55 Primary Care based staff to provide services to the six Dudley Primary Care Networks (PCNs). These staff are employed by us and provide clinical services to PCNs in a number of specialities under the PCN Additional Roles Reimbursement Scheme. We have also appointed to key roles in our corporate teams, using fixed term contracts and secondments, to support the safe delivery of our services and planning for our future growth.

A snapshot of our staff at 31st March 2021 is below.

	Headcount
Mental Health	**23**
IAPT	**37**
High Oak	**11**
PCN ARRS roles	**55**
Pharmacy	**16**
CHC	**19**
Corporate	**60**
Total	**221**

Following the year end, on 1st April 2021, the Dudley School Nursing team TUPEd into DIHC, and we also took on a further cohort of PCN ARRS staff, meaning our staff numbers have continued to grow.

Our workforce are supported by our experienced, passionate, and committed Board. As well as being responsible for

the day-to-day running of the organisation and its performance, the Board also provides compassionate leadership and sets the organisation's strategic aims, which have a strong emphasis on creating a great place to work, a restorative and just learning culture, and a culture of inclusivity. These ambitions align to the NHS People Plan.

Our Services

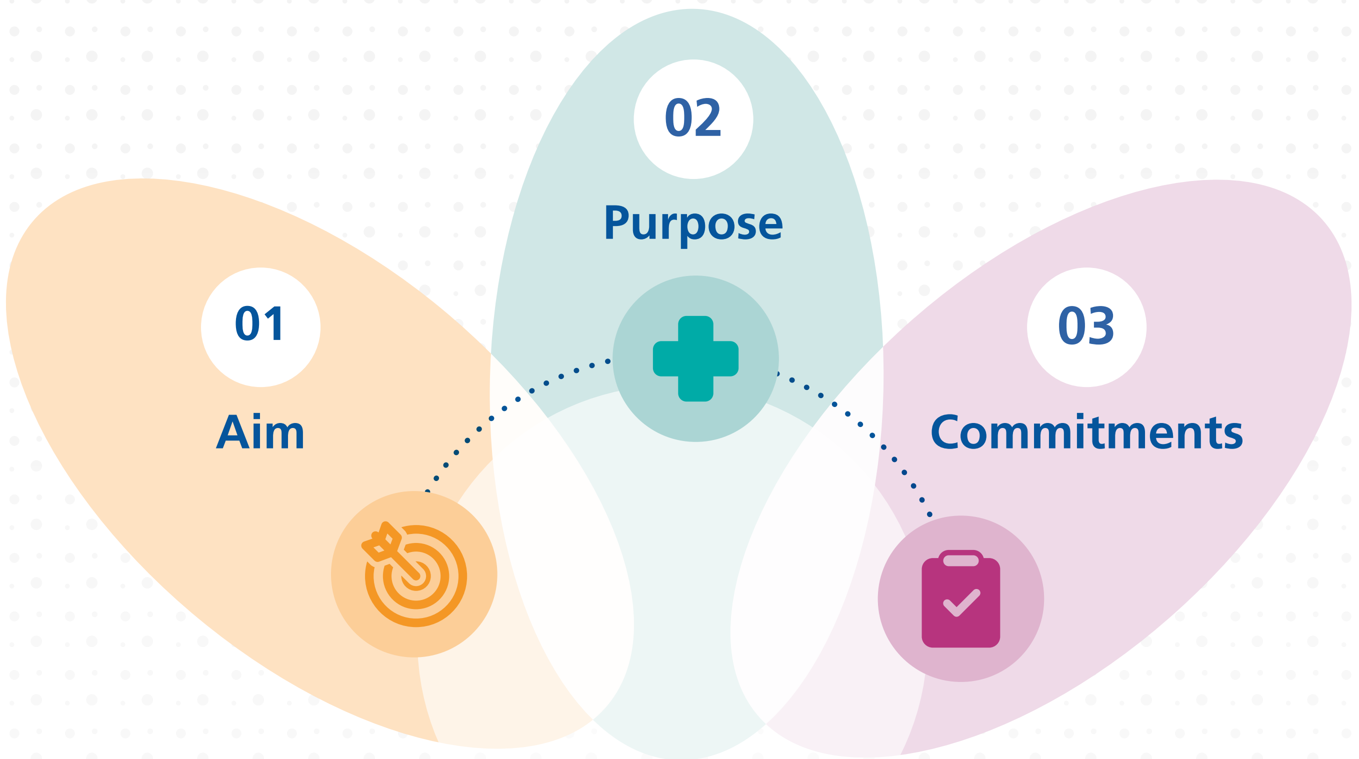
Our clinical services are summarised below.

DIHC Team	Brief Summary
Adults Continuing Health Care (CHC)	CHC is the package of care arranged and funded by the NHS for individuals who are not in hospital but have complex on-going healthcare needs. The DIHC NHS Continuing Healthcare Team provide assessment services on behalf of Dudley CCG who currently fund the packages of care.
Children's and Young Peoples' Continuing Care (CC)	CC is the package of care for children and young people who have complex on-going healthcare needs that cannot be met by existing universal or specialist services alone.
High Oak Surgery	A comprehensively equipped GP practice run by DIHC.
Mental Health Services: Dudley Talking Therapy Services	Part of the national Improving Access to Psychological Therapies (IAPT) programme. Provides psychological support to over 16s in Dudley by offering a number of evidence-based therapies, advice and information.
Mental Health Services: Primary Care Mental Health Services	Supports individuals 16 and over who are experiencing a range of mental health problems. Primary care mental health nurses work from GP surgeries, offering assessment and brief intervention as part of Dudley's Integrated Care Teams (ICTs).
Pensnett Respiratory Assessment Centre	A primary care hub for symptomatic patients in Dudley needing to be seen by a health care professional through the COVID-19 crisis.
Pharmaceutical Public Health	Team of clinical pharmacists providing support to every GP practice in Dudley with the aim of optimising the use of medicines by the people of Dudley.
Range of Primary Care Services	This includes services as described in the Primary Care Network Additional Roles Reimbursement Scheme, and includes Social Prescribing Link Workers, First Contact Physiotherapists, Health and Wellbeing Coaches, Pharmacists, Physician Associates, Podiatrists, Care Co-ordinators, Dietitians, Paramedics and Occupational Therapists.

We have a dedicated senior team providing leadership, management and back office support to our clinical services. We also buy in some support services from other organisations. Notably, in 2020/21 we bought in a significant amount of managerial and back office support from Black Country Healthcare NHS Foundation Trust whilst we were growing our own functions and capabilities.

Our Aim, Purpose and Commitments

During our first year, we have developed a clear Aim, Purpose and set of Commitments for our Trust.



Aim	Purpose
Dudley first: community where possible, hospital where necessary. We are truly different. We are a new type of NHS organisation created to serve our Dudley population in a genuinely integrated way.	To connect with the people of Dudley, embrace our diversity and support them to live longer healthier lives. We will do this by ensuring everyone involved in the provision of care works together, keeping the person at the heart of everything they do.

Commitments

Put people first

We will:

- Care and advocate for all.
- Provide the highest quality care.
- Speak up for those who cannot or ask us to.
- Empower our service users to be joint decision makers in their care.

Enable and support our staff

We will:

- Ensure our staff have the skills to deliver our purpose to the best of their ability.
- Put their safety at the forefront of operational delivery.
- Proactively support their health and wellbeing.

Simplify what can be complex

We will:

- Enable our staff to create and innovate.
- Empower them with the skills and resources so they can improve and transform the services they provide.
- Make this a priority freeing up their time to participate.
- Make our services easy to navigate for patients, staff and citizens.
- Work with our citizens to be the co-designers of future services.

Be accountable for our actions

Our job is to serve the people of Dudley and ultimately; they will judge our actions:

- Each of us has a personal responsibility for our decisions and actions; to be leaders. Only through our actions will we build trust and respect for the work we do.
- Be accessible and responsive - listen to our staff, service users and local population; actively seeking those whose voice is quieter than others or those that are 'hard to reach'; and then respond with the means available to us.
- We will behave inclusively, building on our diversity.
- We will encourage our population to be part of our future workforce and service suppliers.

Our Key Achievements in 2020/21

2020/21 has been a year of major achievements on many fronts. We look to 2021/22 with confidence in our ability and in our resilience and we will work tirelessly to provide the citizens of Dudley with the care they richly deserve.

A Year of Clinical Achievement

Mental Health Services

DIHC was proud to inherit from Dudley & Walsall Mental Health Partnership Trust, the local Dudley IAPT and Primary Care based Mental Health Teams. During 2020/21, these teams have enthusiastically adopted new ways of remote working, necessitated by the COVID-19 pandemic. Simultaneously, they have embraced a full development programme across mental health teams. The Primary Care Mental Health Teams and Talking Therapies teams have undertaken three proof of concept models and have redesigned their referral triage processes as a result. In performance terms, these services have exceeded historical KPIs and benchmark amongst the best performers in the Black Country.

The Pensnett Respiratory Assessment Centre (RAC)

In response to the COVID-19 challenge, most health economies established in primary care a 'red centre' of excellence to diagnose, and to refer or treat, those members of the local community suspected of being infected with the virus. The CCG commissioned us to run the 'red centre' in the Pensnett Respiratory Assessment Centre.

The work of the Pensnett Respiratory Assessment Centre has been highly commended. It has allowed GP practices to function well during the pandemic, and reduced the pressure across other parts of the health care system. Feedback from service users has been excellent.

High Oak Surgery

During the year Dudley CCG awarded DIHC an Alternative Provider Medical Services (APMS) contract for a GP Surgery based in High Oak Pensnett. This is a ground-breaking development, with DIHC becoming the first NHS Trust locally to accept and hold such a contract. We believe we are currently the only NHS Trust to directly hold a patient list.

In the months leading up to the transfer of High Oak, we were able to help the practice temporarily relocate from the portacabin-style premises into the purpose-built Brierley Hill Health and Social Care Centre. The former premises were needed for the COVID-19 Assessment Centre. In 2021/22 we will engage in a Public Consultation to inform the future location of the Practice.

Working closely with GP colleagues, since being awarded the APMS contract on 1st October 2020 we have worked to transform the service offering at High Oak, and this initiative has represented a genuine opportunity to test our principles of integration in practice.

The practice had relied heavily on locums for many years. We have moved non-medical staff onto Agenda For Change contracts, and have engaged the services of four salaried doctors (two appointed as Clinical Leads), thus moving away from any reliance on temporary staff.

As a consequence:

- staff morale is improving;
- our GP-Patient survey results are excellent;
- our quality scores (Dudley Quality Outcomes For Health) are improving; and
- flu and other vaccine rates are better than ever.

We anticipate High Oak becoming a teaching practice for GPs in the next year and will explore the possibilities of training other staff groups, especially Nursing Assistants and PAs within our Primary Care Network (PCN).

Pharmaceutical Services

Our Pharmaceutical Public Health team joined the Trust in October this year and has worked tirelessly with system colleagues to implement and deliver the COVID-19 vaccination programme to the Dudley population. Of particular note has been the team's success in implementing the vaccination programme across the six primary care sites, the Black Country Living Museum, and all Dudley care homes. Collectively these services have vaccinated around 180,000 people, with the pharmacy team playing a key role in safe vaccine handling and governance within the sites.

The Dudley Prescribing Ordering Teams have continued to provide great support to local GP practices during the year.

Monitoring Medication Incident reported through the RLDatix system is a key role of the team. During 2021 there was a focus on collaborative work with Dudley Group NHS Foundation Trust around communication of medicines changes post discharge from hospital.

The COVID-19 pandemic has detracted from the pharmacy team's usual focus on antimicrobial stewardship, but some work has continued. The Medicines Optimisation Quality Incentive Scheme rewards practices for making improvements in prescribing, focussing on overall volume, volume of amoxicillin prescribed, volume of broad spectrum antibiotics (the C drugs) and choice of antibiotic for urinary tract infections. Audit work in practices has examined the treatment of urinary tract infections, with baseline audits being completed in 2020-21 and an improvement process planned for 2021-22.

Continuing and Intermediate Healthcare

Continuing Care and Intermediate Care Teams also joined the Trust in October, from Dudley CCG. Of note this year, is the significant work these teams have undertaken during COVID-19, to support local Dudley care homes and the pressures on the wider system.

Research & Development

During 2020/21 DIHC formed a Research and Innovation group with the support of the National Institute of Health Research (NIHR) West Midlands Clinical Research Network (CRN). Other major success areas were:

- pioneering Dignio Oximetry@Home remote monitoring of COVID-19 patients, thus reducing hospital admissions
- hosting a first major research project, RAPTOR, assessing point-of-care COVID-19 tests.

Our Key Achievements in 2020/21 *continued*

A Year of Cementing our relationships with Primary Care

DIHC's relationship with primary care in Dudley is unique and is at the heart of our organisation. Whilst relationships with primary care are integral to our everyday working, it is important to note that, during 2020/21 DIHC has:

- Established a Primary Care Integration Committee (a DIHC Board Committee) to foster close working between the Trust and Primary Care.
- Developed the integrated care model with primary care, which is supported by 40 signed integration agreements with local GP practices.
- Been awarded an Alternative Provider Medical Services (APMS) contract for High Oak Surgery.
- Facilitated local PCNs delivery of their Directed Enhanced Services (DES) brief by providing local Additional Roles Reimbursement Scheme (ARRS) services.

A Year of working with service users and local communities

DIHC has facilitated over 40 opportunities for our local communities and stakeholders to get involved with us during 2020/21, including:

- Collaboration with Dudley Healthwatch on "Reset, Restore and Recover" and "Bereavement Matters" Programmes.
- Sessions with Dudley College students on Talking Therapies using interactive jam-boards technology.
- Work with the Dudley Young Health Champions and Dudley Youth Council in hosting sessions with local GPs – "a day in the life and the COVID-19 challenge".
- Regular public events with the Dudley Healthcare Forum and Patient Opportunity Panel.
- Facilitating local events with GPs to promote the reality that primary care is 'open for business' and to tackle misinformation on COVID-19 and vaccines.
- Developing easy read information for patients with learning disabilities on Talking Therapies in collaboration with Dudley Voices for Choice.
- Holding events during Mental Health Awareness Week to promote the Dudley Talking Therapy Service.
- Working collaboratively with Dudley Voices for Choice and service users to understand what a good 'health check' should look and feel like to make improvements to the service.

A Year of working with System Partners

DIHC has led the development of the Dudley Place model of integrated care with system partners including The Dudley Group NHS Foundation Trust, Black Country Healthcare NHS Foundation Trust, Dudley Metropolitan Borough Council, Primary Care and Dudley Voluntary Services. This has seen the evolution of the Dudley Partnership Board into a Dudley Integrated Care Partnership Board that will continue its development in readiness for April 2022.

DIHC has worked at all levels as a key partner of the wider Black Country and West Birmingham ICS and wider NHS West & East Midlands Networks, attending a large number of system-wide strategic and operational forums. Of particular note is our work with system partners on silver and gold command calls, with a number of public agencies, including the British Army, as a key part of the system COVID-19 response.

A Year of good governance and financial probity

The Trust was formed on 1st April 2020, with a full complement of executive and non-executive directors, constituting a highly effective unitary board of directors from day one of operation. The Trust has developed effective standing orders, standing financial instructions, policies and procedures, which reflect the best NHS governance practice. We have evolved a detailed substructure of board committees and discussion forums, which promote operational excellence, even in the context of remote and long-distance working during the COVID-19 pandemic.

The Trust has worked well with our principal Regulators, NHS Improvement and the Care Quality Commission and has worked hard to ensure compliance with our numerous other stakeholders and regulatory authorities as responsible custodians of our service portfolio.

We have developed an excellent risk assessment and management system that guides our management focus and prepares us for uncertainties through the early identification of mitigating actions and contingency positions.

We have invested in the financial administration and management of public funds through the design of a bespoke chart of accounts and coding hierarchy and the successful commissioning of a new DIHC general ledger suite facility.

We have successfully managed the Trust’s funds during 2020/21 and have posted a small financial surplus for the year.

Performance Against Our Objectives

To support the delivery of our aim, in 2020/21 we agreed a set of short-term tactical objectives. Our balanced view of progress against these objectives is set out below.

Objective	1. Award of the ICP contract
Anticipated Outcome	Successful completion of transactions review and ISAP processes to provide high quality patient services to the Dudley population on 1st April 2021.
Status	Ongoing
Progress	A business case was developed and submitted in October 2020 to support the award of the ICP contract on 1st April 2021. However, due to a number of challenges, the process was paused and the contract was not awarded. Whilst the contract award date is now expected to be later than originally planned, progress has been made: • Expansion of the Trust through the transfer of a number of services into DIHC on 1st October 2020 and 1st April 2021. • A confirmation between system partners to work together in support of the contract award and service transfers. This objective is ongoing and has rolled forward into our strategic objectives for 2021/22.

Objective	2. Integrate and develop existing services
Anticipated Outcome	Provide and develop our patient services to a high standard, undertaking improvement work where required.
Status	Achieved
Progress	The services within DIHC have been supported through a process of integration and development to focus on improving the quality of services and population health during the year 20/21.

Objective	3. Safe transfer of services into DIHC
Anticipated Outcome	Plan and co-ordinate effectively the safe and smooth transfer of services into DIHC.
Status	Achieved
Progress	While there has been a rephasing of the transfer dates, a number of services have been safely, effectively and smoothly transferred to DIHC during the year 2020/21. These services have been integrated and supported to focus on improving the quality of services and population health.

Objective	4. Define the organisation required from 1st April 2021
Anticipated Outcome	Plan and develop the organisation required for award of contract on 1st April 2021 (engaging and involving existing and transferring staff in the organisational development).
Status	Achieved
Progress	An ongoing development programme of clinical and corporate governance arrangements alongside enhancements to strategic and operational effectiveness has been in place throughout 2020/21. This has involved extensive engagement with staff and stakeholders to shape DIHC.

Objective	5. Establish robust governance arrangements
Anticipated Outcome	Implement RLDatix and define & implement integrated assurance framework.
Status	Achieved
Progress	Robust governance structures have been embedded with the full implementation of RLDatix alongside a range of corporate and clinical governance processes to underpin the DIHC our incident and risk management framework.

Objective	6. Development of Primary Care
Anticipated Outcome	Development of primary care provision for all practices who are fully integrated and develop the DIHC Full Integration Strategy.
Status	Partially Achieved
Progress	Extensive engagement with primary care in 20/21 has enabled DIHC to develop an understanding and methodology by which to approach the development of full integration. Our acquisition of High Oak has proven our ability to operate Primary Care directly, improving quality and efficiency.

Objective	7. Maintain effective contribution to system response to COVID-19
Anticipated Outcome	Work with system partners on the system response to COVID-19, Dudley Respiratory Assessment Centre.
Status	Achieved
Progress	Teams and individual staff within DIHC have made an exceptional contribution to the COVID-19 response, either directly through the provision of face to face assessments for patients with COVID-19 symptoms at the Pensnett Respiratory Assessment Centre, through the support of the biggest vaccination programme undertaken in England or through support of the mental and physical health of the population. As an organisation we are immensely proud of and grateful to our staff and our colleagues across the wider system for their commitment and resilience during such a difficult year.

Objective	8. Establish the Trust as a key clinical and system partner
Anticipated Outcome	Work with local system and regional partners to develop the Dudley and Black Country systems.
Status	Achieved
Progress	DIHC staff have worked collaboratively throughout the year to support our partners across the system.

Objective	9. Demonstrate effective use of resources
Anticipated Outcome	Make efficient and effective use of financial, workforce and estate resources.
Status	Achieved
Progress	DIHC has demonstrated appropriate financial diligence and utilised our staff appropriately while recognising that most staff have been appropriately working from home with risk assessments in place where staff are working in clinical and office settings.

Looking forward

Our focus during 2021/22 will be to continue on our development journey as an Integrated Care Provider, to develop our own services, support the restoration of local place services, and to work collaboratively with local system partners to implement an integrated care partnership in Dudley. To support these ambitions, we have developed ten strategic objectives for 2021/22. Our Business Plan describes how we will achieve these objectives and how we will measure our success.

Award of the ICP contract to DIHC

Integrate and develop existing services

Ensure the safe and smooth transfer of services by 1st April 2022

Develop and deliver the DIHC Organisational Development Strategy

Be a learning organisation that is rooted in the heart of the local community

Development of the working partnership between DIHC and Primary Care

Work with the system partners to restore services effectively

Develop DIHC as lead provider in the place based integrated care partnership

Demonstrate effective use of resources and be a sustainable organisation

Develop the full Integration Strategy for Primary Care

Our Key Risks and Issues

Our Board Assurance Framework (BAF) details the principal risks to the achievement of our strategic and operational plans. It is informed by internal intelligence from performance, incidents, complaints, audit as well as the ever-changing environment in which we operate.

The eight key risks to our plans were identified as:

- There is a risk to the ICP contract not being awarded, or significantly delayed, due to pressures on the local system, transfer of services from within the health system and the workforce skills/capacity required to deliver service changes.
- There is a risk that there are insufficient resources in place to safely and effectively manage existing services; improve existing services; or to effectively manage the extended scope of business required for future service improvement and partnership working.
- There is a risk that there are insufficient resources and systems in place to safely and effectively manage the transfer of additional services into the organisation.
- There is a risk that the governance arrangements that are put in place to manage the business and its planned development are not as connected, adaptable, agile, responsive or supportive of the innovation and transformation required to meet our strategic objectives; this could result in a decision-making process that is slow, leading to a failure to deliver clinical services effectively and efficiently and potentially could impact on patient safety.
- There is a risk that the Trust is unable to meet demand in relation to the COVID-19 response.
- There is a risk that the Trust is unable to effectively engage with its system partners and demonstrate appropriate system leadership.
- There is a risk that our financial sustainability will be impacted by future changes to the NHS financial regime, which could see resources diverted from our Trust and result in significant financial / cost pressures.
- There is a risk that the Trust will not be able to recruit, train and retain the appropriate innovative workforce required to deliver the transformational Integrated Care Provider ambitions for service users.

More detail on how we manage risk can be found in the Annual Governance Statement.

Going Concern

Our current size and small turnover warrants specific consideration of our sustainability.

Whilst there is a presumption of going concern status for NHS Trusts that deliver services that will be provided by the public sector both now and in the future, our first accounts also reported a small operating surplus and we are, at the time of this report, planning a balanced budget for 2021/22. This is a major achievement for a newly formed Trust within the current economic climate and with the ongoing financial and operational impact of the ongoing pandemic.

We are confident in our future growth, which will enable us to reach a more stable and sustainable size and income base. Dudley Integrated Health and Care NHS Trust, The Dudley Group NHS Foundation Trust and Black Country Healthcare NHS Foundation Trust have been working together in the local system to further integrate healthcare services for all in Dudley. The local system will actively pursue the transfer of children's services and community services to Dudley Integrated Health and Care NHS Trust from Black Country Healthcare NHS Foundation Trust and The Dudley Group NHS Foundation Trust, and aim to transfer these services by 1st April 2022, subject to the appropriate assurance processes.

Impact of COVID-19

The COVID-19 response has served to test the NHS and social care's resources, resilience and capacity – and has revealed how robustly services can respond through collaboration and integration to a crisis through the sheer will, determination and resilience of the workforce.

At DIHC this has been demonstrated by the extensive partnership with primary care, secondary care providers and acute partners across all levels, from front line service delivery to board commitment and support, for all the needs of the Black Country and West Birmingham STP and not just for our own service users across Dudley. One example has been the work of our pharmacy team to support the mass vaccination programme that has been undertaken by GP practices across Dudley alongside the vaccination of our most vulnerable residents in nursing and care homes.

COVID-19 Assessment Centre

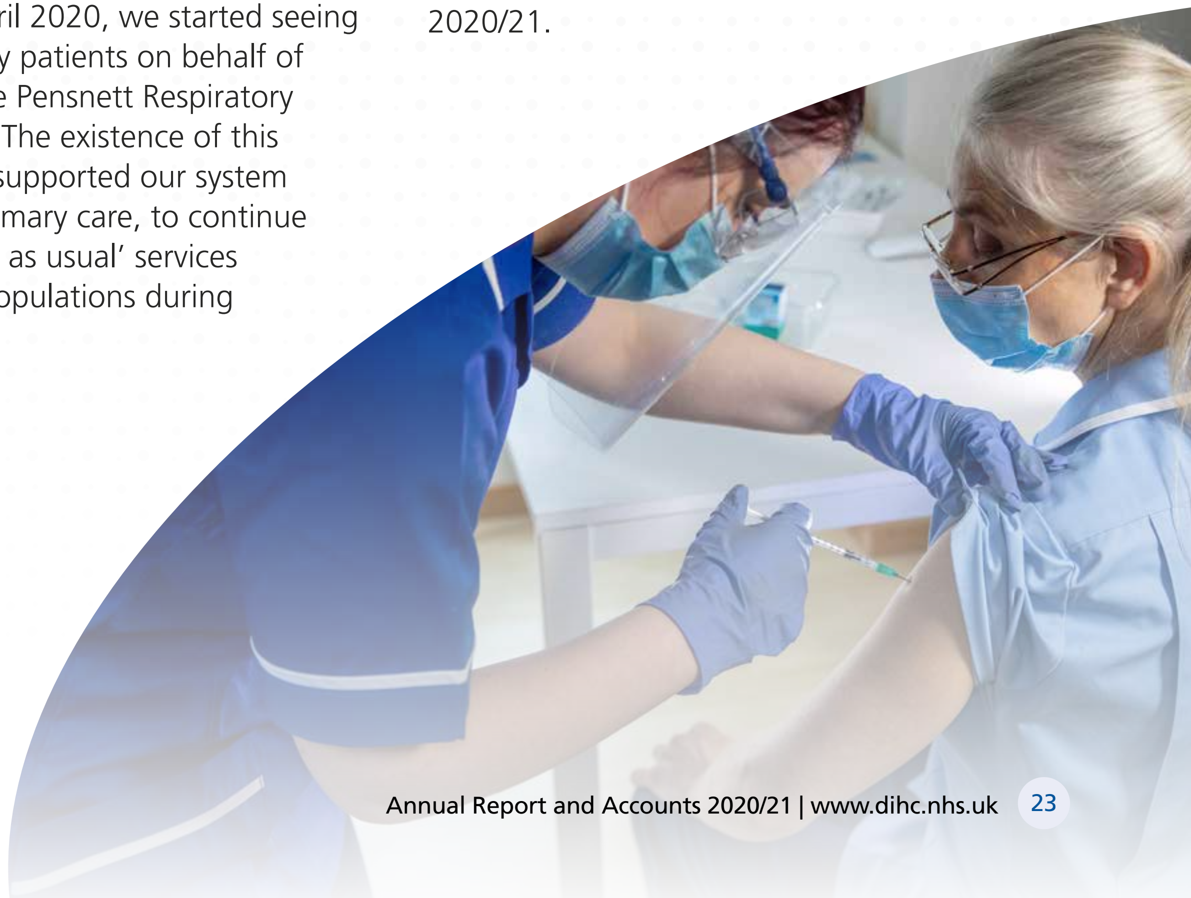
Following the first national lockdown on 23rd March 2020, DIHC was commissioned on its first day of existence (1st April 2020) to operate a COVID-19 assessment centre. Three working days later, on 6th April 2020, we started seeing out first COVID-likely patients on behalf of all Dudley GPs at the Pensnett Respiratory Assessment Centre. The existence of this Assessment Centre supported our system partners, notably primary care, to continue to offer vital 'service as usual' services to their registered populations during the pandemic.

Setting up the COVID-19 Assessment Centre required close partnership working with local PCNs and practices. We swiftly developed a small core team of GPs, nurses and managers to run the Centre, with strong support from Future Proof Health Ltd, the Pharmaceutical Public Health Team, the CCG's IT Team and our Communications Team. We worked with primary care to streamline the referrals and triage process, and dynamically flexed staffing levels with support from the PCNs as the waves of the pandemic came and went; in the second half of the year, we recruited a number of COVID-19 Care Co-ordinators for Primary Care Networks.

As the Pensnett Respiratory Assessment Centre became established we developed two research interests:

- Trialling the use of "Dignio" remote monitoring technology in COVID-19 patients.
- Recruiting patients for the Oxford University RAPTOR study to assess the efficacy of various Lateral Flow Tests against PCR tests.

We now know that quick assessment and treatment saves lives and reduces length of stay. We are proud to have run the Pensnett Respiratory Assessment Centre during 2020/21.



Impact of COVID-19 on our other services

The response to COVID-19 has inevitably had an impact on the way in which services have been provided, with the majority of clinical work being undertaken remotely and face to face services only being delivered in strictly controlled situations which are risk assessed. Teams have responded professionally and innovatively to the situation and done everything they can to maintain patient access to care.

Our staff have needed to continually risk assess situations, and adapt to wearing and managing personal protective equipment (PPE). Together they have rapidly developed and are utilising new pathways of care to triage, redirect or manage patients dependent on their risk of COVID-19. The collaborative work to support the care of patients at the end of their lives has been particularly important, alongside reviews to ensure that we learn any lessons in respect of care provided to those patients.

We have seen a need for significant training, communication and engagement across the health and social care system alongside working with other public sector partners. In addition the development of innovative remote ways of working and digital solutions for telemedicine has fundamentally and dramatically changed the way health care is delivered. As we move forward to a phase in which services are restored, we want to build on and strengthen the level of innovation regarding remote access and digitalisation.

Impact of COVID-19 on our staff

Staff have responded swiftly and positively to the emerging situation, ensuring that they followed guidance and provided access to patient care through a process of risk assessment. Service staff who maintained face to face contact have adapted to enhanced infection prevention and control processes. Many other staff have needed to work from home, and some have experienced isolation.

We have offered our staff access to emotional and psychological support during this challenging time, recognising that their experiences both professional and personal have placed significant pressure on their health and wellbeing. We have also supported our staff in adopting enhanced flexible and home working arrangements.

Our staff have told us that they acknowledge and really appreciate the support they have received from the Dudley community who, alongside other parts of the country, have done so much to encourage and recognise the contribution of the NHS staff. Services have received positive feedback, alongside gestures of support and thanks for their commitment and contribution.

CASE STUDY

Health coaching at Lion Health

Heather (not the patient's real name) had been referred to the health coach at her local practice by her GP. Heather is aged 57 years old with type 2 diabetes, at high risk for heart disease, has hypertension and generalised osteoarthritis.

She had been to see her GP with back pain and other generalised pain and the GP had noticed she was withdrawn, seemed in low mood and needed to lose weight. They discussed being referred to the pain clinic and taking medication but Heather was adamant she didn't really want to bother anyone and she definitely did not want to be stuck on medication. The GP recognised she was perfect for the health coaching team and made a quick referral to them.

Two weeks later, health coach Jo made contact with Heather over the phone due to COVID-19. They chatted for an hour and Heather told Jo that over the last two years her mobility had decreased, she'd had a major operation, her mood was quite low and she'd sadly lost several family members to COVID-19. 'I don't want to go on anti-depressants and I want to do this myself," she said. Heather also recognised that she didn't have any support at home.

Jo and Heather chatted about increasing her confidence and capabilities and Jo reminded Heather of the resilience she had shown. At the end of the hour, Heather set herself two small goals to achieve that she felt were doable:

- Cut out chocolate
- Go for a short walk every day

Four weeks later Jo and Heather spoke again over the phone. Heather had lost three pounds in weight and she was feeling more flexible, less achy and not getting so breathless when she was out walking. In addition, she was feeling more positive in mood.

Three weeks later, Jo and Heather spoke again. Heather had managed to lose half a stone and her mood was still increasing and she felt motivated to keep going. Heather and Jo will be speaking again in three weeks' time.

When Heather was asked about the impact of health coaching on her she replied, 'This has been tremendous, It's an emergency cord for me. Just having someone who is interested in me and that I can talk to makes a difference.'

Jo added that the additional telephone conversations only last around twenty minutes and despite COVID-19 she is thrilled she can still help patients which is the best part of her job.

Performance Analysis

This Performance Analysis contains a detailed performance summary. It includes:

- A Performance Dashboard
- A Quality, Safety and Experience Summary
- Health and Safety
- Emergency Planning
- A Service User and Staff Voice Summary
- An Equality, Diversity and Inclusion Summary
- Sustainability and the Net Zero NHS Ambition
- A Financial Summary

As a redesignated Trust, we have prepared this report and accounts as a continuation of DWMH, but have omitted to display trend information from previous years within our Performance Report as this information is not comparable to our current operations.

Performance Dashboard

To support the delivery of the key performance indicators within the oversight framework we monitor using an integrated performance dashboard.

Dudley Integrated Health and Care Trust Scorecard 2020-21					
Area	**Type**	**No.**	**Metric**	**Target**	**Outturn**
Quality Care Outcomes		1	CQC Rating - Community MH Services **(NOTE 2)**		Good
		1a	CQC Rating - High Oak Surgery **(NOTE 2)**		Good
	Caring	2	Written complaints – rate (number of written complaints per WTE staff)		1.3%
	Safe	3	Occurrence of any Never Event		0
	Safe	4	Patient Safety Alerts not completed by deadline		0
	Safe	5	Serious Incidents		1
	Caring	6	Staff Friends and Family Test % recommended – care **(NOTE 3)**		Not available
	Caring	7	Mental Health scores from Friends and Family Test – % positive		99%
	Effective	8	Data Quality Maturity Index (DQMI) – IAPT dataset score **(NOTE 1)**	95%	Avg. 97.5% per month
	Effective	9	IAPT Access rate as a rate of prevalence		15.65%
	Effective	9b	% Number of people entering treatment against target	100%	68.8%
			Number of people entering treatment – Trajectory		7743
			Number of people entering treatment - Actual		5327
	Effective	10	Percentage of people completing a course of IAPT treatment moving to recovery	50%	45.6%
	Effective	11	Percentage of people waiting i) 6 weeks or less from referral to entering a course of talking treatment under IAPT	75%	97.2%
	Effective	11b	Percentage of people waiting ii) 18 weeks or less from referral to entering a course of talking treatment under IAPT	95%	99.1%

Dudley Integrated Health and Care Trust Scorecard 2020-21					
Area	**Type**	**No.**	**Metric**	**Target**	**Outturn**
Leadership and Workforce	Organisational Health	12	Staff Sickness		2.04%
		13	Staff Turnover		9.14%
		14	NHS Staff Survey **(NOTE 4)**		76.36%
		15	Proportion of temporary staff		18.30%
		16	**Reducing/eliminating bullying and harassment from managers and other staff Providers (NOTE 4)**		**12%**
		16a	% experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public		11%
		16b	% experienced harassment, bullying or abuse at work from managers		16%
		16c	% experienced harassment, bullying or abuse at work from other colleagues		8%
		17	**Effectiveness of shared objective-setting and teamworking Providers**		**71%**
		17a	% agreeing that their team has a set of shared objectives		65%
		17b	% agreeing that their team often meets to discuss the team's effectiveness		76%
		18	**Providing equal opportunities and eliminating discrimination Providers**		**93%**
		18a	% staff believing the Trust provides equal opportunities for career progression or promotion		89%
		18b	% experiencing discrimination from their manager/team leader or other colleagues in the last 12 months		3%
		19	**The BME leadership ambition (WRES) re executive appointments. (NOTE 5)**		
Finance	Financial Sustainability	20	Capital service capacity		0.2
		21	Liquidity (days)		139
	Financial efficiency	22	Income & Expenditure (I&E) margin		0.37%
	Financial Controls	23	Distance from financial plan		£38,000 favourable
		24	Agency spend		55.39% favourable
		25	Overall Score		2

Points to note:

1. Data Quality Maturity Index (DQMI) – IAPT dataset score was not available for February and March at the time of reporting.
2. Dudley Integrated Health and Care NHS Trust is a new organisation and has not had a CQC inspection. We have reported the latest CQC scores for those services which have transferred into the organisation:
   - The latest CQC score for IAPT and Primary Care Mental Health service refers to the legacy organisation Dudley and Walsall Mental Health Partnership NHS Trust - Community based MH services for Adults and Older Adults. The inspection took place in January 2020 and was published in March 2020.
   - The latest CQC Score for High Oak Surgery was inspected in September 2016 and published in October 2016.
3. Staff FFT was postponed due to the coronavirus pandemic
4. There were only two services (IAPT and Primary Care Mental Health) eligible to participate in the staff survey.
5. Dudley Integrated Health and Care NHS Trust have not participated in the WRES. Our ambition is to grow diversity within the executive team and work towards at least 20% of the board being from a BAME background over the next 5 years.

The dashboard above shows strong performance in many areas. Worthy of comment are the below metrics:

- Our IAPT performance is below target. We have seen challenges due to a number of vacant hard-to-recruit posts in the IAPT team, exacerbated through the in-year introduction of our first contact practitioner model. We have however seen some improvements in our IAPT performance since 2019/20 (when the service was part of Dudley and Walsall Mental Health Partnership NHS Trust).
- Our staff survey was limited to the two mental health services, and as a consequence the number of respondents was very small. The percentage of staff who reported experiencing harassment, bullying or abuse must be seen in the context of the very small number of total respondents to this survey (only 38 responses were received in total). The Executive are working closely with the teams to support improvements in team culture.
- Our capital service capacity is low. On 1st April 2020, DIHC received a loan from Black Country Healthcare NHS Foundation Trust. Whilst in its infancy, DIHC has not yet generated surpluses to service the financing and capital repayment of this loan, although has been able to make payments as they fall due up to the date of this report and expect to do so for the remaining loan term.

Managing Performance

Over the course of 2020/21, we have continued with the use of PC-MIS and the data warehouse provided by the Black Country Healthcare NHS Foundation Trust Business Intelligence service. This has enabled continuity of support to front line services whilst informing strategic and operational decisions at all levels of the organisation.

The Trust has also been working with the Midlands and Lancashire Commissioning Support Unit (MLCSU) to enhance its Business Intelligence function.

The key achievements for business intelligence development in 2020/21 include:

- Enhanced internal Business Intelligence reporting supported by the MLCSU.
- Development of the population health outcomes framework reporting in preparation for the commencement of the Integrated Care Provider contract.
- Identification of the data warehouse requirements in order to develop the future in-house Business Intelligence service.
- Scoping of the future Business Intelligence function requirements for the Trust.

The key aims for Business Intelligence and Performance 2021/22 will include:

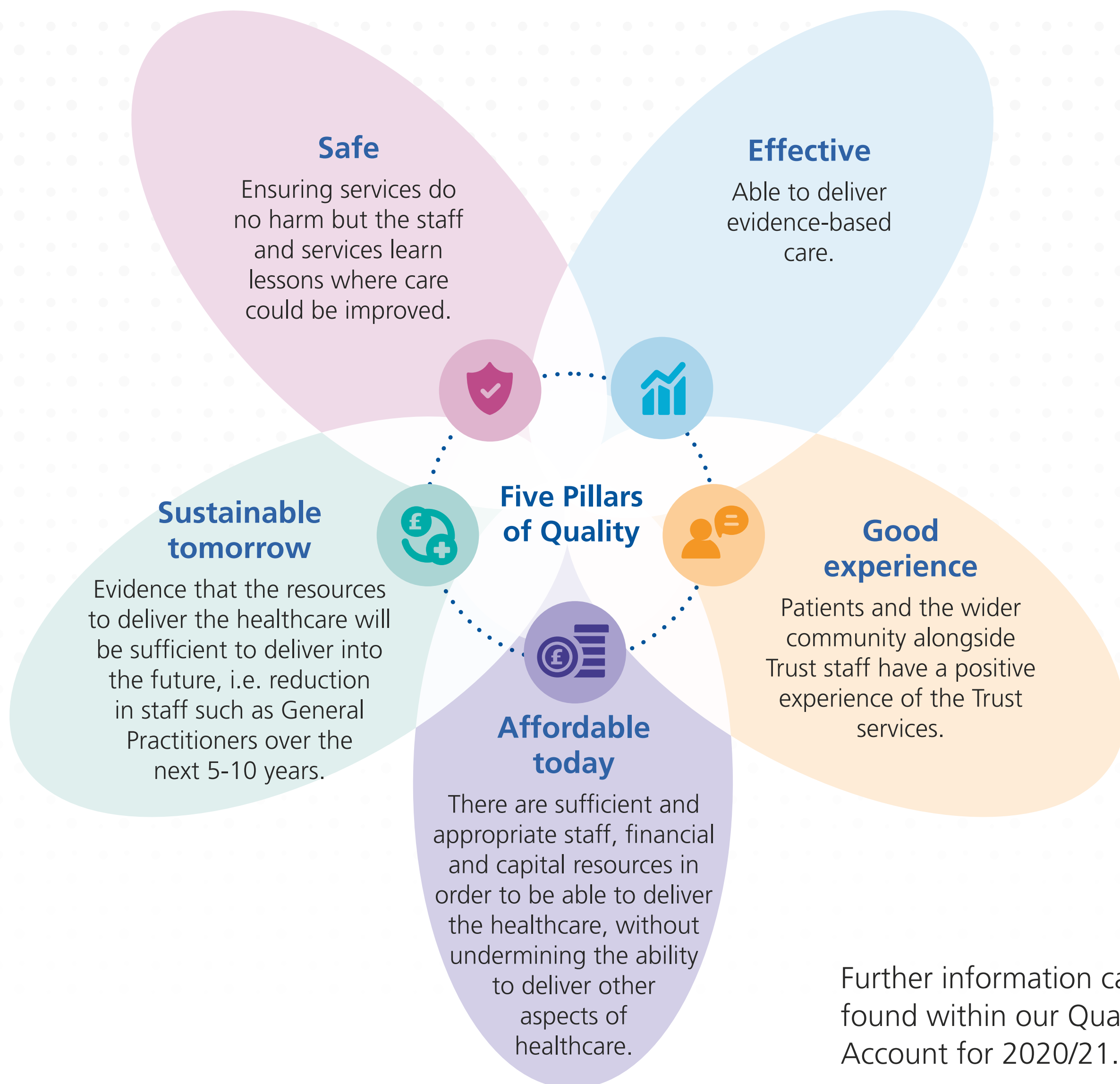
- Continued development and implementation of performance and information reporting for the Trust.
- Continued rollout of EMIS clinical system to existing services and the School Health Nursing Service.
- Review existing information systems to ensure that they are fit for purpose for an integrated provider Trust.
- Develop and update the Performance report to reflect 2021/22 contractual Key Performance Indicators (KPI), specifically focussing on national KPI metrics during the first half of the year.
- Produce Trust information submissions to reflect all statutory returns, such as IAPT and Community Data Set (CSDS).
- Maintain full compliance with the Data information Standards.
- Identify and develop data quality processes to ensure that data is accurate, timely and fit for purpose.

04 Quality, Safety and Experience

This first year has undoubtedly been focussed on developing and establishing systems and processes that enable us to keep people safe, but it has also been a time of continuous and rapid development involving a number of services transferring into our newly-formed organisation.

These transfers of clinical services have been underpinned by a principle of 'safe landing', putting the continuity of service and quality at the forefront of any change, and have enabled us to bring a number of services together and establish processes that will support future service transfers.

Underpinning our approach to quality and safety we have defined our 'Five Pillars of Quality':



Further information can be found within our Quality Account for 2020/21.

Our Quality Priorities

In 2020/21, we set ourselves five initial Quality Priorities, in addition to the ongoing development of clinical services, designed to support the further development of the Trust's culture of inclusion, safety and experience. These were:

1. Implementation of RLDatix for incident and feedback management.
2. Development of the Equality, Diversity and Inclusion work programme.
3. Development of the Trust's Safeguarding infrastructure 'across the life course'.
4. Capturing the patient experience of using the Pensnett Respiratory Assessment Centre.
5. Support the system delivery of the NHS COVID-19 vaccination programme providing appropriate leadership, pharmaceutical oversight and support.

These priorities have been aligned to our pillars of quality as well as the wider Trust Integrated Governance Framework, overseen by our Quality & Safety Committee. Each priority was underpinned by a number of key objectives designed to enable us to achieve the required outcomes.

These initial priorities have also provided a foundation for identifying further objectives for 2021/22, in line with the planned growth of the organisation.

Below is a summary of the progress we have made over the year.

1: Implementation of RLDatix	
Why is this a priority for improvement?	DIHC places emphasis on being a learning organisation to drive improved experiences for staff and patients. The Trust will continuously improve patient safety and will support a clinical governance infrastructure that is responsive and supportive. To enable this within DIHC a patient safety reporting database is necessary. RLDatix is a bespoke web-based software product that provides functionality across a number of areas of clinical governance.
Outcomes	Following a procurement exercise RLDatix was commissioned and went live on 1st April 2021, providing functionality initially for managing incidents and service user feedback with risks and safety alerts to follow early in 2021/22. A significant amount of work took place during 2020/21 which engaged staff across a number of services in developing and configuring the system. The RLDatix system is a key building block for the DIHC patient safety strategy and further strengthens the established patient safety reporting to the Quality & Safety Committee and the wider Trust. The Associate Director of Governance and Quality and the Deputy Director of Nursing having been identified as the Trust's Patient Safety Specialists to provide a robust blend of clinical and non-clinical expertise and to ensure resilience.

2: Develop the Equality Diversity and Inclusion Work programme	
Why is this a priority for improvement?	Diversity and Inclusion in the workforce leads to improved health and greater staff and patient experiences of the NHS. A diverse workforce enables the Trust to deliver a more inclusive service and improved patient care. The Trust wants to ensure that its workforce represents the community we serve and to recognise and value differences through inclusion and enable DIHC to shape the future of healthcare and its workforce through becoming a more inclusive employer.
Outcomes	The Trust has implemented an Equality Diversity and Inclusion Committee chaired by the CEO. This demonstrates the significant emphasis the Board are placing on this agenda. An objectives and inclusion plan has been developed (2020-2022) comprising of four key workstreams; • Recruitment and Selection. • Developing data and evidence. • Communication and Engagement. • Education. Guidance on writing Job Descriptions and person specifications that avoid discrimination and bias has been developed as has a process and guidance on values and competency based recruitment. The Board has endorsed the Trust's anti-racism campaign.

3: Develop the Trust's safeguarding infrastructure 'across the life course'	
Why is this a priority for improvement?	DIHC shares the belief that living a life that is free from harm and abuse is a fundamental right of every person. The Trust is fully committed to providing safe, effective, responsive and accountable care for all service users, as determined within their corporate strategic intentions which promises to deliver "unmatched quality of care for every time we touch lives" across Dudley borough. DIHC NHS Trust has a statutory duty to ensure it makes arrangements to safeguard and promote the welfare of children, young people and to protect adults at risk from abuse and neglect in accordance with both the Children's Act (2004) and the Care Act (2014). All staff employed by DIHC have responsibility for safeguarding children, young people and adults.
Outcomes	An overarching Safeguarding Strategy was presented to the Quality and Safety Committee in March 2021. This strategy is for 2021/22 and sets out **'Our Vision for Safeguarding'**. The strategy will evolve and will support the Trust to develop a robust safeguarding infrastructure which alongside a work programme for Safeguarding which amongst other elements will; • Demonstrate that we have appropriate systems and processes in place in order to discharge our statutory duties in terms of safeguarding children and adults. • Ensure that the voice of the child, young person or adult is captured wherever appropriate in order to better measure outcomes and benefits as perceived by individuals. The Trust's Safeguarding Adults and Children's policy was presented to the Quality and Safety committee in March 2021 and is a Trust wide all service policy which outlines corporate and individual responsibilities in accordance with legislation, guidance and standards. As part of its governance structure the Trust is developing a Safeguarding Committee. During 2020/21 assurance on safeguarding has been received direct to the Quality and Safety Committee. The newly formed Safeguarding Committee will report into the Quality and Safety Committee. Finally the Trust has engaged with Dudley Safeguarding People Partnership Board (DSPBB) to ensure the Trust is fully represented within the DSPBB governance structures in order that the Trust may provide assurance on its activities and work in partnership with the Board to focus on the following priorities. • Neglect across the life course. • Preventing Harm across the life course. • Exploitation across the life course.

4: Capture the patient experience of using the COVID-19 Assessment Centre	
Why is this a priority for improvement?	The NHS faced an unprecedented challenge during 2020/21 due to the coronavirus pandemic. As a result GP led 'red-sites' were implemented to provide a place to see patients with coronavirus symptoms face to face. Dudley's 'red-site' was the Pensnett Respiratory Assessment Centre. Primary care had to rapidly develop a triage model of care with the ability to review face to face those individuals with symptoms of COVID-19. In addition the centre was responsible for treating patients across the borough of Dudley working to a very different model which included remote monitoring.
Outcomes	Our survey of the Pensnett Respiratory Assessment Centre site was incredibly positive. 90% of respondents said they were satisfied with the service they received. A large majority of respondents (94%) had no problems finding the site and felt the instructions they received for attending an appointment were good while 97% said they were well advised on what to do when arriving at the Pensnett Respiratory Assessment Centre.

5: Support the system delivery of the NHS COVID-19 vaccination programme providing appropriate leadership, pharmaceutical oversight and support	
Why is this a priority for improvement?	2020/2021 saw the unprecedented challenge of a global pandemic. Groups most disadvantaged before the pandemic had a relatively high number of COVID-19 infections and deaths.
Outcomes	DIHC are supporting the system wide response particularly with the Pharmaceutical Public Health team. The Trust is aware that there are inequalities in the immunisation uptake across different groups within the community. The Trust worked with the Local Authority to bring in skilled engagement teams to increase uptake. The Primary Care Networks also adopted the same approach to work with organisations that support the hard to reach communities. DIHC Pharmaceutical Public Health team spoke to individuals and gave support where possible, to encourage uptake. Activity and engagement to support the increase in uptake included; • Identifying people who require an interpreter in community languages or British Sign Language; • Support to people with learning disabilities and their carers; • Women-only vaccination clinics; • A wide education piece to address the ability of Muslims observing Ramadan (from 12th April) to accept vaccination. Our Pharmaceutical Public Health team joined the Trust in October 2020 and has worked tirelessly with system colleagues, to implement and deliver the vaccination programme to the Dudley population. Of particular note has been the team's success in implementing the vaccination programme across all Dudley care homes together with the clinical vaccination administration support provided through the Continuing Health Care team. Everyone in cohorts one to nine, in the most risks groups, has been offered a vaccination in Dudley. At the end of April 2021 94% of the over 50s had received at least one vaccination in Dudley with 90% of over 45s having received a first vaccination. It is acknowledged that the programme continues into 21/22 and that primary care, together with our pharmaceutical public health colleagues continue to support a magnificent effort to keep the population of Dudley vaccinated and safe.

As part of our development of quality priorities for 2021/22, we have defined five key areas:

1. Developing service user and staff engagement & feedback.
2. Integrated primary care and community pathway development.
3. Underpinning clinical systems and processes.
4. Protecting and supporting vulnerable people.
5. Inclusivity and equitable access.

Incident Reporting and Management

The table below is a record of all the incidents reported to the National Reporting and Learning System (NRLS), which is a central database of patient safety incident reports. All NHS Trusts are required to report patient safety incidents to the NRLS every week. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care. This level of transparency provides an opportunity for the NHS at both local and national level to share experiences and learn from them.

2020/21	
Total incidents reported	No. incidents resulting in severe harm or death
39	1

A total of 39 patient safety incidents were reported during 2020/21 with only one meeting the criteria for reporting as a Serious Incident in February 2021. The investigation does not indicate there was any direct link to the services we were providing.

No Never Events have been reported during 2020/21.

Clinical Audit and Effectiveness

Clinical audit is a fundamental part of the quality improvement process. It plays an essential role to provide assurances to the public about the quality of our services. Findings from clinical audit are used to ensure that action is taken to protect patients from any risks associated with their care and treatment.

Clinical audit is managed at service level with the support of the medical directorate, with the Quality & Safety Committee approving the annual programme of clinical audits and having oversight of progress during the year.

The pandemic has curtailed much of the audit programme that would typically have been undertaken. However, the Trust has ensured that it has remained focussed on required audits and those most pertinent to improving patient safety.

Pharmaceutical Public Health Team

The transfer of the Pharmaceutical Public Health team into DIHC brought with it a strong track record for delivering clinical audit, primarily through the team of practice based pharmacists, but also through collaboration with Birmingham University School of Pharmacy, providing valuable experience for their undergraduates.

The team's resources available for carrying out clinical audit has been particularly impacted by COVID-19 given their support to the setting up and delivery of the COVID-19 vaccination programme. However, they have continued to support key audits, both within the Trust and across wider primary care including:

- Audit of steroid card provision to ensure patients are issued with and carrying warning cards.
- Valproate audit – a continuous audit to ensure female patients are being supported by the Valproate Pregnancy Prevention Programme which aims to reduce the risk of birth defects associated with the treatment.
- Audit of communication between the local hospital and GPs relating to the provision and continued monitoring of the effects of COVID-19 treatments.
- Oversee the audits required by practices through the Medicines Optimisation Incentive Scheme (MOQIS), predominantly antibiotic audits.

As an organisation we are committed to the principles of the NHS constitution supporting research and innovation, and are establishing an organisational culture to embrace this. We recognise the value gained by supporting research and innovation in systems, services, pathways and patient experience to identify the best evidence-based approach to improving health and care.

As a result we have formed a Research and Innovation group with the support of the National Institute of Health Research (NIHR) West Midlands Clinical Research Network (CRN). This group's purpose is to ensure that our Trust is a research positive environment, raising the awareness of the importance of research and innovation but also to enable staff to explore ideas and share learning and good practice.

The group is led by the Medical Directors and will ensure that the Trust follows the UK Policy Framework for Health and Social Care Research[2] to become a research-ready organisation, and ultimately a research-active organisation. The Framework sets out the principles of good practice in the management and conduct of health and social care research and ensures that the public will feel safe when they take part in research.

The Trust recognises the importance of giving our patients wider access to clinical research and understands that evidence[3] shows research active NHS organisations have better patient care outcomes. Funding has been made available by the Trust so all of our teams will have access to information and support to take part.

Research and Development undertaken in year includes:

- pioneering Dignio Oximetry@Home remote monitoring of COVID-19 patients, thus reducing hospital admissions.
- hosting a first major research project, RAPTOR, assessing point-of-care COVID-19 tests.

2 https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/

3 https://pubmed.ncbi.nlm.nih.gov/29438805/

Care Quality Commission (CQC)

Since the Trust was established, we have not been subject to any CQC inspections; those services which do require CQC registration are currently rated as good based on the latest inspections undertaken by CQC. These are summarised below.

	Safe	Effective	Caring	Responsive	Well-led	Overall
IAPT	Good	Good	Good	Good	Good	Good
PCMHS	Good	Good	Good	Good	Good	Good
High Oak Surgery	Good	Good	Good	Good	Good	Good

During each of our phases of expansion, as services have transferred into the Trust, we have engaged with CQC and continue to do so as we plan for next year's development.

Health and Safety

We are committed to providing a healthy and safe environment for service users, visitors and staff, at all Trust properties.

During 2020/21 Health and Safety and Fire Safety Advice and Training was supplied by a service level agreement with Black Country Healthcare NHS Foundation Trust.

This year has understandably seen a focus on COVID-19, with regular individual and workplace risk assessments being undertaken. A shift to more remote or virtual working for some aspects of our clinical services has played a key role in safety for staff and service users with regards to COVID-19.

The introduction of our Pensnett Respiratory Assessment Centre has supported both our own High Oak Surgery and other GP practices in Dudley to maintain the safety of staff and patients when providing essential face to face consultations for patients suspected of having COVID-19.

Towards the end of this year our emphasis has switched towards preparation for a return to face to face clinical work whilst still employing the benefits of remote working that have been developed over the year.

Incident investigations

All Health and Safety related incidents are reported via an online incident reporting system. The Health and Safety Advisor monitors all Health and Safety related incidents and carries out investigations where required.

The Reporting of Injuries, Diseases and Dangerous Occurrence Regulation (RIDDOR)

To ensure compliance with the requirements of "The Reporting of Injuries, Diseases and Dangerous Occurrence Regulations" (RIDDOR), accidents and incidents are reported (when required) to the HSE. In the last year there have been 0 incidents reported to the HSE.

HSE Inspectors

We have not received any notices of Improvement, Prohibition or Enforcement from the HSE or the Care Quality Commission (CQC) in relation to matters of Health and Safety.

Emergency Planning

The NHS needs to plan for and respond to a wide range of incidents and emergencies that could affect health or service user care. This could be anything from extreme weather conditions to an infectious disease outbreak or a major transport accident or terrorist attack. This work is referred to in the health service as "Emergency Preparedness, Resilience and Response (EPPR)" and is underpinned by legislation contained within the Civil Contingencies Act and the NHS Act 2006 (as amended) and the NHS Standard Contract.

Emergency planning stems from the national security risk assessments and the local community risk register. To support these assessments, national business resilience planning assumptions set the standards we have to work to in mitigating those risks. This builds a requirement for us to produce specific emergency plans to react to incidents involving those risks.

Our statutory role is to be able to respond to internal and external incidents, supporting other health economy organisations and other 'responder' organisations as identified in the Civil Contingencies Act. As part of our internal arrangements, we must have the ability to respond 24/7 to any incident and must maintain a suite of emergency and business continuity plans, embedding emergency planning as a culture within the organisation.

Under the Civil Contingencies Act 2004 (CCA), there is a statutory requirement for all NHS organisations categorised as Category 1 or Category 2 responders to have appropriate emergency planning and business continuity arrangements in place.

This means that the focus for the Trust is on developing and embedding appropriate business continuity arrangements. This ensures it can effectively meet the challenges of incidents that can disrupt the continuity of its critical and essential services as described by the NHS England Emergency Preparedness, Resilience and Response Framework 2015.

The minimum requirements, which providers of NHS funded services must meet, are set out in the current NHS England Core Standards for EPRR. The standards are in accordance with the CCA 2004 and the NHS Act 2006 (as amended).

The NHS Standard Contract Service Conditions require providers to comply with the EPRR guidance. Therefore, commissioners must ensure providers are compliant with the core standards as part of an annual assurance process.

Business continuity is about maintaining our ability to deliver prioritised services during a critical incident or emergency situation e.g. a major security incident or an influenza pandemic. Effective business continuity management is therefore about the identification, management and mitigation

of particular risks to our ability to deliver these essential services. The Trust has a Business Continuity Management Policy (BCM) and associated Business Continuity Plans to meet this need. The services that transferred to DIHC have business continuity plans in place and these have been reviewed to reflect how the services operate within DIHC.

The model adopted accords with the best practice expectations placed upon all NHS organisations in the NHS England Business Continuity Management Framework (service resilience) 2013 and the associated requirements listed in the NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR).

The Business Community Management Policy describes the strategic framework of how the Trust manages its business continuity planning. Both business continuity support and EPRR have been provided to DIHC by Black Country Healthcare NHS Foundation Trust as part of our service level agreement arrangements. This has included participating in the major incident response to COVID-19.

DIHC have also undertaken a significant role in the Local Authority response to the COVID-19 outbreak and also supported the Clinical Commissioning Group on the incident management response.

A comprehensive new programme has been created to increase knowledge and understanding of emergency planning and how key role holders within the organisation can effectively contribute to service delivery, response and recovery during a major incident. Training will be a continual ongoing cycle of learning and will be reviewed annually.

Service User and Staff Voice Summary

As an integrated provider we aim to involve and listen to our service users, their families and carers.

We are passionate about ensuring that we reach as many people as possible and give them the support and confidence they need to have a voice and feel valued. We are actively working with partners across Dudley, including Healthwatch, Black Country Healthcare NHSFT, Dudley Group NHSFT, NHS Black Country and West Birmingham CCG and Dudley Metropolitan Borough Council to harmonise and strengthen our approach. With this in mind, we are working to develop a new, person centred, model of care which:

- Understands the position, needs and motivation of people and communities.
- Works with people and communities to hear their voices.
- Engages with people and communities to build relationships and offer genuine opportunities for involvement and influence.
- Embraces the assets of people and communities to create opportunities for co-production, building collaborative relationships that recognise that different roles and perspectives are a constructive force for change.
- Empowers staff to lead service changes to benefit people.
- Enables people and communities to put themselves at the centre of their care – so that they can make informed decisions about their health and wellbeing – be supported to manage their conditions and stay independent and as in control as possible.
- Creates an environment to support people using health and social care to drive change themselves.

We also recognise that some of our partners, particularly the voluntary sector have stronger and trusted relationships with different parts of our communities so we seek to work with them to develop trust and understanding.

We are wrapping health and wellbeing around our patients – putting them at the centre of their care and in control. We are actively integrating our services and are not stifled by the bureaucracy of organisational boundaries. We adopt a "teams without walls" approach and strive to work with each other and our patients and their families/carers to ensure they have the help, support, care and information that they need to live life as independently as possible in the way that they need.

Primary care is at the centre of our integration having the overall lead and coordination of patient care for all. The beauty of our Primary Care Network workforce is that they are integrated with our community and primary care and able to respond flexibly to the needs of different people and communities, recognising that we don't need a 'one size fits all' approach. The workforce are developed based on the needs of the local population and we empower our local communities to take control and responsibility for their health and happiness and use an asset based approach to build community connections and cohesion.

Taken together, these approaches improve health outcomes and experiences and we allocate resources more efficiently to areas of need and want – especially for those with long term conditions and complex care needs.

At DIHC we are totally committed to working in partnership to achieve a collective vision that benefits not only people and communities, but the staff that are a huge part of making this transformational change happen.

Although we have adapted to the challenge of COVID-19 and remote engagement, we know that once restrictions are lifted we look forward to being able to go out to be part of our communities again, encouraging conversations, connections and ideas.

Involving and listening to our service users

Understanding service user experience is important to us, this helps us to ensure that our services are developed and improved to meet service users' needs through listening to peoples' experiences and views, responding comprehensively to feedback and demonstrating what has been improved as a result. The following are a selection of indicators chosen by the Trust as important measures of patient experience.

With outcomes forming a huge part of DIHC we are shifting into a culture of true patient empowerment. Patient and public involvement is at three levels:

- Co-production at a public engagement level – through the development or co-design of services and by having conversations about self-care and health & wellbeing. We engage with a range of people that reflect our diverse community and work with our voluntary and community sector partners and groups to extend our reach.
- Co-production at a patient experience level – for example, surveys designed with patients based on our understanding of real time issues by evaluating data collected through surveys and complaints.
- Co-production at an individual level through care planning, goal setting, shared decision making, self-management and medicines optimisation. By working in partnership we support people to empower themselves to manage their own conditions and live healthier and happier lives.

Service User Experience

Complaints, Concerns and Compliments

The Trust recognises the value in listening to feedback from our service users, including complaints, and we are committed to providing an accessible complaints process and a robust and transparent process for investigating and learning from complaints.

A total of 15 formal complaints were received by the Trust during 2020/21; none of these have been referred to the Parliamentary Health Service Ombudsman.

Although no obvious themes have been identified from the small number of complaints, a number were related to the perceived attitude of the staff involved, largely with services being provided via remote consultations. This is being reflected on as part planning for more face to face work alongside continuing remote sessions.

The Trust also received 13 compliments relating to both our mental health services and the Pensnett Respiratory Assessment Centre.

Involving and listening to our workforce

We support a culture that is based upon working openly and collaboratively to provide high quality services that put the experience of our service users at the heart of all that we do.

Around 220 staff work for the Trust, the majority of whom are clinicians and "front-line" staff. They are our most important resource and without their dedication, we would not be able to provide the services that we do.

Communication is central to every organisation. When used effectively it supports the creation of a positive working environment, cements working relationships with internal and external stakeholders and sets the tone for the entire organisation.

We recognise that building a culture of two-way communication, is crucial in helping to ensure that staff feel recognised and valued. In order to develop and maintain effective communications, the Trust promotes a culture that:

- Is open, transparent and clear.
- Encourages staff to suggest new ways of working.
- Supports constructive feedback.

Throughout 2020/21 we continued to strengthen how we communicate and engage with staff which has increased involvement and positive feeling amongst colleagues. We have established our Freedom to Speak Up guardians to support our staff in raising concerns and also have our staff side representatives who meet regularly with our People directorate.

We have also built our social media presence producing more content and creating a closed staff Facebook group preparing for the enlarged Trust where we post regular updates and other relevant content for existing staff and those about to transfer in.

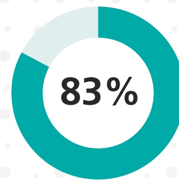
Across the Trust there a number of ways in which we engage and communicate with our staff including:

- Trust Intranet development which involves our staff.
- A Welcome Pack for all staff that describes the organisation and includes key information.
- Welcome meetings on the 1st of each month led by our Chair, Chief Executive and Executive management team. These are currently undertaken remotely but will move to face to face as soon as practically possible.
- Additional welcome meetings for new teams transferring into the organisation.

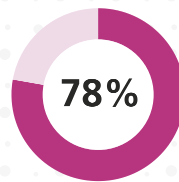
- Fortnightly `Ask Paul' session for all staff to attend and ask any question of our Chief Executive and our Executive management team.
- Monthly DIHC Development sessions for all staff with our Director of Operations, Strategy and Partnerships/Deputy Chief Executive updates staff on the development and progress of DIHC.
- A fortnightly remote Coffee Break led by our communications team which provides staff with the opportunity to relax and chat with colleagues across the organisation about anything they want to, attempting to replicate those corridor conversations and aiding staff connectivity and wellbeing.
- The weekly Friday Round Up which is our newsletter with a foreword from the Chief Executive and which contains useful information and opportunities.
- Monthly Manager Meetings for all team managers led by the Chief Executive and information is subsequently cascaded to teams.
- Monthly catch up meetings for teams ahead of their transfer into DIHC which increase to fortnightly during the six weeks prior to transfer.
- An active twitter account which is growing followers steadily: **https://twitter.com/IHCDudley**.
- An active Facebook account which is growing steadily: **https://www.facebook.com/IHCDudley**.
- A closed Facebook account for our staff to access.

Only two of our teams were able to participate in the national staff survey due to the size of the organisation, therefore we undertook our own survey and the survey results were excellent.

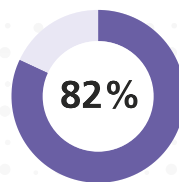
All responses were above **75% positive**, and some highlights are:



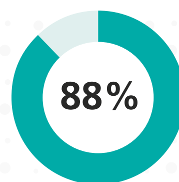
of staff feel welcomed and part of the team by DIHC



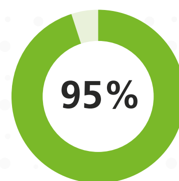
of staff feel communication is effective



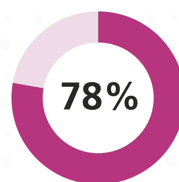
of staff feel their voice is heard



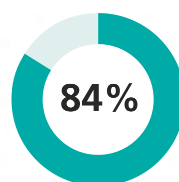
of staff feel their health and wellbeing is important to DIHC



of staff feel trusted to do their job



of staff would recommend DIHC as a place to work



of staff are looking forward to continuing in their work with DIHC.

Comments from staff on DIHC from our latest internal staff survey include:

"I think the communication channels for staff are generally good especially given the challenges of remote working."

"A very welcoming organisation with a lot of effort made to make new staff and transferring staff feel welcome."

"I know there are engagement sessions when I can speak and also an anonymous way of contacting the organisation."

"I genuinely feel that DIHC care about me. The communications feels friendly and reassuring."

We are incredibly proud to achieve these results, especially as this has been a year of turbulence for many of our staff and teams.

Health and Wellbeing of our Staff

The health and wellbeing of our staff is of paramount importance and particularly after the experience of this particular twelve months. The range of health and wellbeing options we have for our staff are:

- Vivup Employee Scheme app which provides advice and discounts in a number of areas including gym memberships.
- Employee Assistance Programme which includes 24 hour advice line for mental health and psychological wellbeing.
- Promotion of psychological wellbeing applications such as Headspace, Unmind, Sleepio and Daylight.
- Access to the Black Country wellbeing hub.
- Promotion of "Looking After You Too" which is an individual coaching support offer for Black, Asian, and Minority Ethnic staff working in the NHS.
- Promotion of Christian Counselling Offer available to NHS staff.
- A range of physical health advice including promotion of the "Doing our Bit" free fitness programme for NHS staff.
- Providing a range of suggested exercises for desk workers.
- Advice on nutrition, sleep, work/life balance and hydration, and access to one of our many professionals should it be required.
- Creation of "ground rules" for promoting a healthy work life balance with some agreed working practices including ensuring breaks between meetings, limiting the amount and length of meetings and flexible working.

Involving Our Partners and Stakeholders

We continue to focus on developing meaningful relationships with our wider stakeholders ensuring they are kept up to date with Trust developments and providing them the opportunity to influence the delivery of services through two-way communications and engagement.

Over the coming year there will be a continued focus on strengthening partnership working. Central to the management of our relationship with our stakeholders is the development of our integrated care model. We have transferred services from five organisations during our first year; all of these transfers involved close working with our stakeholders and partners to ensure the smooth and safe transfer of the services.

These transfers are as follows:

- The Primary Care Mental Health and Dudley Talking Therapies (IAPT) teams from the previous Dudley and Walsall Mental Health NHS Partnership Trust.
- Services including the Continuing Healthcare and Intermediate Care teams, the Pharmaceutical Public Health Team, the Prescribing Ordering Direct team and corporate staff teams from Dudley Clinical Commissioning Group.
- Staff and services in High Oak Surgery.
- Primary Care Network staff and services from FutureProof Health Ltd.
- The School Nursing staff and service from Shropshire Community Healthcare NHS Trust.

DIHC was proud to inherit from Dudley & Walsall MHP Trust, the local Dudley IAPT and Primary Care based Mental Health Teams. During 2020/21, these teams have enthusiastically and brilliantly embraced new ways of remote working, necessitated by the COVID-19 pandemic. Simultaneously, they have embraced a full development programme across mental health teams. The Primary Care Mental Health Teams and Talking Therapies teams have undertaken three proof of concept models and have redesigned their referral triage processes as a result. In performance terms, these services have exceeded historical Key Performance Indicators and benchmark amongst the best performers in the STP.

In response to the COVID-19 challenge, most health economies established a "red" centre in primary care. The Pensnett Respiratory Assessment Centre has been a demonstration of excellence in accommodating, diagnosing and referring or treating, those members of the local community suspected of being infected with the virus. It provided timely care in a safe environment for patients and staff. The High Oak surgery kindly relocated on a temporary basis to establish this facility. The work of the Pensnett Respiratory Assessment Centre has been highly commended to have allowed local GP practices to function well during the pandemic and additionally to reduce the burden of COVID-19 presentations at Russell's Hall Hospital.

During the year DIHC has also been awarded by the local CCG an APMS contract for the High Oak GP Surgery based in Pensnett. This is a ground breaking development with DIHC becoming an NHS Trust to accept and hold such a contract. Working closely with GP colleagues, the Trust has worked to transform the service offering at High Oak and this initiative has represented a genuine opportunity to test our principles of integration in practice.

Our Pharmaceutical Public Health Team joined the Trust in October 2020 and has worked tirelessly with system colleagues, to implement and deliver the vaccination programme to the Dudley population. Of particular note has been the Team's success in implementing the vaccination programme across all of the Dudley Care Homes.

The Dudley Prescribing Ordering Teams have continued to provide great support to local GP practices during the year.

Our excellent Continuing Care and Intermediate Care Teams also joined the Trust in October, from Dudley CCG. Of note this year, is the amazing work these teams have undertaken during COVID-19, to support local Dudley Care Homes and discharge processes from the local acute hospital.

We continue to involve all stakeholders and partners in the development of the care model and most importantly the integrated care pathways for our local population.

DIHC has led the development of the Dudley Place model of integrated care with system partners such as Dudley Group NHSFT, Black Country Healthcare NHSFT, Dudley Metropolitan Borough Council, Primary Care, Dudley Voluntary Services etc. This has seen the evolution of the Dudley Partnership Board into a Dudley Integrated Care Partnership Board that will continue its development in readiness for April 2022.

DIHC has worked at all levels as a key partner of the wider Black Country and West Birmingham and wider NHS West & East Midlands Networks, attending a large number of system-wide strategic and operational fora. Of particular note is our work with system partners on silver and gold command calls, with number of public agencies, including the British Army, as a key part of the system COVID-19 response.

CASE STUDY

Starting a new job in the middle of a national pandemic - making the most of it

Chris is employed by the Brierley Hill & Amblecote Primary Care Network as a Social Prescribing Link Worker for the over 70s. This was a new role within a newly formed team for the PCN to support the elderly and frail patients and help prevent unnecessary appointments.

As Chris started his role just as the national COVID-19 pandemic was gripping the nation, he said, 'In normal times, as a team changes or grows, if you are unsure of something you could just go and ask a colleague, or you could shadow someone to learn the role, but this was a new role within a new team during a pandemic, so we have all been learning as we have gone along.'

However this changed as the planning got underway for the vaccination sessions; Chris and the wider team were called upon for their help. The sessions helped Chris to build trust and rapport with his colleagues across the other surgeries within his PCN and understand the different roles and how they all connected into each other. Chris said, 'As a new service for the GPs and surgeries, with working from home it has been hard to generate referrals, so the vaccination sessions have been a great way to spread the word to staff and people about what we do, which has led to queries and referrals. I want to help people so being part of a team that is providing vaccinations is a great feeling, the positive comments from the majority of people receiving their vaccine are a real lift in otherwise strange times.'

Chris went on to say that Dr Tapparo, the PCN Clinical Director said she is very proud of how the team have pulled together to support the vaccination programme and can see the benefits of building the relationships that will be integral to the roles, as things start to get back to normal.

So despite COVID-19 providing a really challenging time to start a new job, Chris has made the most of it and used the opportunity to promote the service and connect with others.

Below are some of the activities we have undertaken during the year.

Commissioners	• Attended local Mental Health Programme Boards. • Attendance at STP/ICS meetings. • Development of the ICP contract and implementation of the model of care. • Participated in monthly Contract and Quality Review Meetings. • Worked in partnership to develop services and pathways and address gaps. and inconsistencies in service provision. • Worked closely with CCG communications teams to support local initiatives such COVID-19 response, winter campaign, long term plans and place-based care.
GPs	• Engagement with GPs and commissioners on the development of place based models of care in Dudley. • Highlighted relevant GP information via CCG communications channels. • Clinicians attend regular forums providing education and input to GP Forums. • Fortnightly meetings with Primary Care Network (PCN) Clinical Directors. • PCN Clinical Director attendance at monthly Primary Care Integration Committee. • Maintained communication through the fortnightly Practice Bulletin and monthly engagement events.
Media	• Continued to develop relationships with local media responding to enquiries and proactively promoting news. • Concentrated on building our regional profile including items on BBC Midlands Today, local radio stations and newspaper articles. Continued to develop relationships with local media responding to enquiries and proactively promoting news. • Built on our national, regional and local profile.
Service users and the community	• Over 40 opportunities for engagement and information shared with local people, communities and wider stakeholders. • Regular meetings with the public through the Healthcare Forum and the Patient Opportunity Panel – representative of Patient Participation Groups. • Supported some campaigns throughout the year such as Mental Health Awareness Week.
Local NHS providers, public sector / third sector organisations	• Throughout 2020/21 we have worked closely with our NHS Provider partners to respond to COVID-19 and to continue to develop integrated pathways and developing the model of care in Dudley. • We work with our NHS, council, voluntary sector and Healthwatch colleagues on the Dudley Partnership Board to develop services for patients. We have particularly focussed on how we develop our collective services for our children and young people. • We have an excellent relationship with Dudley Council for the Voluntary Sector and continue to develop our social prescribing services with Integrated Plus.

We have undertaken political engagement with MPs and Councillors as follows:

- Stakeholder newsletter sent to all MPs, councillors and other stakeholders.
- Undertaken regular meetings with MPs.
- Attend Dudley MBC Health and Well Being Board and Health and Adults Overview and Scrutiny Committees.
- Undertaken regular meetings with Councillors and organise specific early involvement meetings with councillors based on developments within their constituent areas.
- Open door policy for MPs and Councillors to raise issues direct with our Chief Executive and Chair.

This has also been a year for cementing our relationships with Primary Care. DIHC's relationship with primary care in Dudley is unique and is at the heart of our organisation. Whilst relationships with primary care are integral to our everyday working, it is important to note that, during 2020/21 DIHC has:

- Taken responsibility to further support the Primary Care Networks by employing all Dudley PCN staff from October 2020.
- Developed the integrated care model with primary care which is supported by 40 signed integration agreements with our GP practices.
- Fully integrated into our own organisation the High Oak practice, holding a direct APMS contract with the local CCG.
- Facilitating local PCNs delivery of their Directed Enhanced Services (DES) brief by hosting local Additional roles reimbursement scheme (ARRS) staff.

Throughout 2021/21 DIHC has facilitated over 40 opportunities for our local communities and stakeholders to get involved with us during 2020/21, including;

- Ran sessions on using online digital platforms.
- Taken part in the COVID-19 hero nominations.
- Held discussions on end of life and palliative care.
- Presented at a Yemini webinar on COVID-19 with our joint Medical Director speaking Arabic.
- Discussed service transformation.
- Held awareness and update sessions on the COVID-19 vaccine and care homes.

Equality, Diversity and Inclusion Summary

The Office of National Statistics records show the Dudley total population standing at 312,925, of which 20% are aged 30 to 44, and 63,428 (20%) have limiting long-term conditions. Around 11% of the population are from BAME backgrounds. The Learning Disabilities (LD) Outpatient & Community services have supported 3,000 people of which the average age is 35 to 42. There are more males compared to females in LD services. Around 9% of people using LD services in Dudley come from BAME backgrounds. We also have Children, Young People and Families Services in Dudley.

We are committed to supporting the Equality Delivery System (EDS) to support NHS commissioners and providers to deliver better outcomes for patients and communities. It also aims to deliver more personal, fairer and more diverse working environments for staff. The EDS is all about making positive differences to healthy living and working lives.

We will produce our first Annual Equality and Diversity Report, have established an EDI committee, chaired by the Chief Executive, and set up an Inclusion, Anti-racism and Allyship staff network.

Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES)

The WRES and WDES are mandated for NHS Trusts. Whilst DIHC has not been required to formally undertake a WRES or WDES assessment in this period, we have actively worked to ensure that we are an organisation that supports race and disability equality.

We are a Disability Confident employer, and have established our Anti-Racism campaign. We have also undertaken improvements in our recruitment processes and training for managers to ensure fairness and transparency.

We are committed to a culture where those working for us are valued and appreciated for the skills and talents they bring and where the needs of those using our services are understood and respected.

We are committed to treating everyone who visits or works for us with respect and as individuals, taking into account their individual differences, personal values and perspectives.

Our successes and achievements

The Trust has successfully completed the following actions to meet its Public Sector Equality Duty (PSED) compliance:

- Equality Delivery System (EDS) and Equality Objectives – The Trust continues to progress with the EDS2 implementation action plan and has successfully achieved progress against the Trust's four equality objectives.
- Accessible Information Standard (AIS) – Working towards ensuring our data and information is accessible.
- Equality Impact Analysis (Assessments) – Developed the framework for EqIA's for policies, procedures and service development areas.
- Developed the Trust EDI committee.
- Developed a staff network.
- Became a Disability Confident Employer.

Sustainability and the Net Zero NHS Ambition

Climate change is a significant issue from a global perspective and has long-term impacts on health and wellbeing, as well as being one of the most serious global environmental threats. A commitment to sustainability and carbon reduction targets is now included within the NHS Long Term Plan to highlight the impact that working towards sustainable targets contributes to a "service fit for the future".

In addition, the Climate Change Act sets target reductions of 30% by 2030 and net zero percent by 2050 against a 1990 baseline and the Trust is reviewing ways in which the we can further contribute towards the target reduction on a local, regional and international level.

The Board made public commitment to Net Zero NHS Ambition recognising the strategic importance of the sustainability agenda and outlining a holistic range of activities to limit the social, economic and environmental impact of our services and activities as we grow.

We appointed a Non-Executive Director (NED) and Executive Director as leads for Sustainability and continued working with our STP partners to ensure a co-ordinated response to the impact of climate change.

We have developed and implemented a Sustainability Impact Assessment (SIAs) for Policies and Procedures led by the Trust Secretary as Interim Sustainability Lead, with information from the SIAs being used to build a baseline for the Green Plan.

The Trust recognises the importance of its contribution in promoting sustainable development in order to reduce emissions, save money and improve the health of people and communities as it works towards the 34% reduction target for 2020.

Looking forward, the Trust will consider as part of its refreshed strategy opportunities to refresh our sustainable development strategy, including the use of a Salix grant, interest free finance to:

- Refresh our Net Zero NHS strategy, including:
  - Review of an approved three year Green Plan by end-March 2022.
- Develop The Green Plan 2022 to 2025 is to include commitments on:
  - Green Travel.
  - Renewable Energy Commitment.
  - Plastic Reduction Pledge.
  - Net Zero Carbon standards within any future Estates Strategy.
- Receive Quarterly reports on progress towards the Green Plan and on initiatives to embed a sustainable and environmentally conscious culture.
- Explore specialist services to support the Trust in this work, whilst also considering if other opportunities may be viable through our new strategic partnerships.
- Development of a five-year strategy for sustainability, encompassing a number of strands relating to energy consumption, water usage, waste, green travel options, health and wellbeing and workforce.
- Seeking advice from the Sustainable Development Unit to support activity within these workstreams, both on a regional and national level, and the Trust will encompass this activity within the development of the strategy to enable planning for future targets.
- Working with our STP partners to ensure a co-ordinated response to the impact of climate change.

Financial Summary

The Trust performed well financially during its first year of operation as Dudley Integrated Health and Care NHS Trust, in an environment challenged by several factors including the COVID-19 pandemic and uncertainty regarding the timing of service transfers.

The table summarises the Trust's performance against the key financial duties for the year ended 31 March 2021.

Requirement	Target	Performance	Outcome
Expenditure does not exceed income	Breakeven	£38k surplus	Achieved
Remain within Capital Resource Limit (CRL)	0	0	Achieved
Achieve capital cost absorption rate of 3.5%	3.5%	3.5%	Achieved
External Financing Limit is not exceeded	£178k	£178k	Achieved

The Trust also maintained a strong balance sheet, with net current assets of £1.8m and total assets of £0.1m (with no material non-current assets). Cashflow was positive, and the Trust closed the year with a cash balance of £4.1m.

Where does the Trust's Income come from?

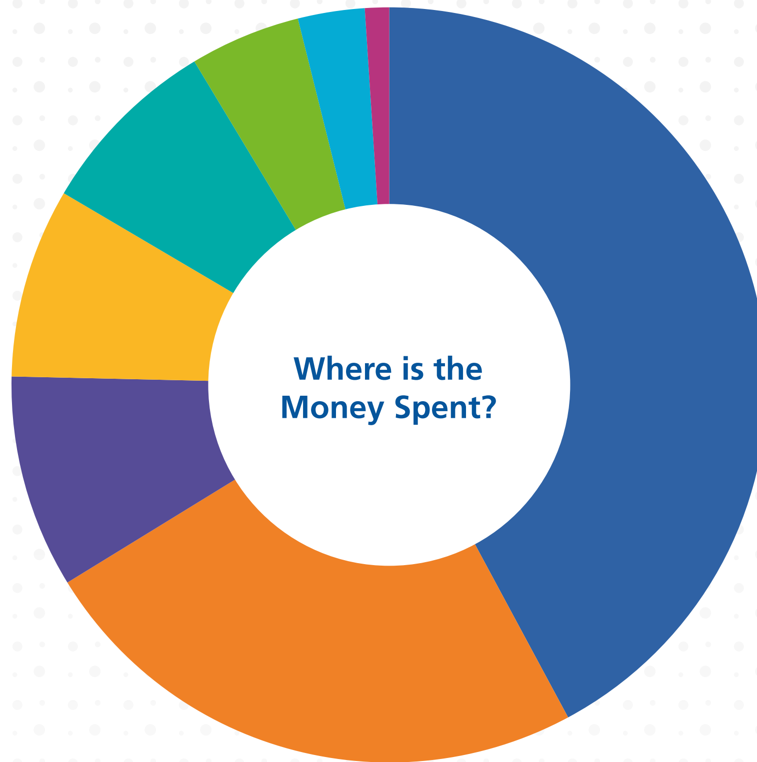
The majority of the operating income is receivable under a contractual arrangement from NHS Dudley CCG as lead commissioner. However, the COVID-19 pandemic resulted in the suspension of existing arrangements and implementation of a new national financial regime in which income became receivable on a fixed, block contract basis. Additional "top-up" funding to cover any remaining operating costs (including that incurred in response to the COVID-19 pandemic) was receivable from NHS England during the first half of the financial year, and from NHS Sandwell and West Birmingham CCG (as lead CCG for the Black Country and West Birmingham System) during the second half of the year. Whilst the first six months saw the Trust able to claim and draw funds as required, the second six months required all organisations within the local Health system to manage collectively within the resources allocated.

How is the Trust's money spent?

The Trust invested the £10,738k resources received in the delivery and management of the services transferred to date, which primarily comprised Primary Care Mental Health and Improving Access to Psychological Therapy services, the High Oak General Practice and the Pensnett Respiratory Assessment Centre. The chart opposite summarises the areas of expenditure.

Corporate costs, including some costs associated with the continued development of the Full Business Case for the award of the Integrated Care Provider Contract (the process for which was delayed by the pandemic), were an abnormally high proportion of overall operating costs during the year. This was due to the phased nature of services transferring into the Trust, the timing of which has also been impacted by COVID-19.

Trust Expenditure by Service Area (chart in £,000)



Corporate Services
£4,573

Mental Health Services
£2,613

Operational Delivery, Quality and Governance
£990

COVID-19 Response
£881

Primary Care Services & Networks
£857

Continuing Healthcare Management
£514

Medicines Management
£310

Non-operating expenses
£112

Capital Expenditure

The Trust did not incur any capital expenditure during its first year of operation, although some non-current assets were transferred into the organisation.

Payment of Suppliers

Better Payment Practice Code

The Better Payment Practice Code (BPPC) requires organisations to aim to pay all valid invoices by their stated due date or within 30 days of receipt, whichever is later. Performance against this target, over the financial year, was as follows:

Better Payment Practice Code Performance

2020/21 Performance	Number	Value £'000
Non-NHS Payables		
Total Non-NHS trade invoices paid in the year	3,218	6,434
Total Non-NHS trade invoices paid within target	2,677	6,054
Percentage of Non-NHS trade invoices paid within target	83.2%	94.1%
NHS Payables		
Total NHS trade invoices paid in the year	187	14,402
Total NHS trade invoices paid within target	171	14,298
Percentage of NHS trade invoices paid within target	91.4%	99.3%

Countering Fraud, Bribery and Corruption

The Trust is committed to ensuring NHS resources are appropriately protected from fraud, bribery and corruption and follows the national counter fraud strategy and the series of standards for providers of NHS services. As an NHS Provider the Trust ensures that NHS funds and resources are safeguarded against those minded to commit fraud, bribery or corruption. Failure to do so impacts on a provider's ability to deliver services and treatment, as NHS funds and resources are wrongfully diverted from patient care.

In order to reduce economic crime against the NHS, it is necessary to take a multi-faceted approach that is both proactive and reactive. The Trust's Local Counter Fraud Specialist (LCFS) follows the four key principles, in accordance with the NHS counter fraud strategy. These are designed to minimise the incidence of economic crime against the NHS and to deal effectively with those who commit crime.

The four key principles are:

1. **Strategic Governance** - this standard sets out the standards in relation to the organisation's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation.
2. **Inform and involve** those who work for, or use the NHS, about economic crime and how to tackle it. NHS staff and the public should be informed and involved to increase everyone's understanding of the impact of economic crime against the NHS. This takes place through communications and promotion such as face to face counter fraud presentations, public awareness campaigns and media

management. The LCFS presents as part of the Trust induction. Working relationships with stakeholders are strengthened and maintained through active engagement.

3. **Prevent and deter** economic crime in the NHS to take away the opportunity for crime to occur or to re-occur and discourage those individuals who may be tempted to commit economic crime. Successes are publicised internally during counter fraud presentations and using other media opportunities so that the risk and consequences of detection are clear to potential offenders. Those individuals who are not deterred should be prevented from committing economic crime by robust systems, which will be put in place in line with policy, standards and guidance.

4. **Hold to account** those who have committed economic crime against the NHS. The Trust's LCFS is a professionally accredited investigator and is qualified to the required standards. Once allegations of suspected economic crime are received by the Trust, the LCFS must ensure that investigations are undertaken to satisfy national legislation. The Trust encourages the prosecution of offenders, and where appropriate refers offenders to their professional bodies for disciplinary sanction. Economic crimes must be detected and investigated, suspects prosecuted where appropriate, and other methods of redress sought where possible. Where necessary and appropriate, economic crime, investigation and prosecution will take place locally wherever possible. Nevertheless, the LCFS also works in partnership with the police and other crime prevention agencies to take investigations forward to criminal prosecution. The Trust has a Counter Fraud Bribery and Corruption Policy in place, which is designed to make all staff aware of their responsibilities, should they suspect offences being committed. When economic crime is suspected, it is fully investigated in line with legislation, with appropriate action taken, which can result in criminal, disciplinary and civil sanctions being applied. In addition, the Trust has the following policies and procedures which support counter fraud work:

- Security Management Policy.
- Standards of Business Conduct Policy.
- Whistle Blowing Policy and Procedure.
- Disciplinary Policy.

I confirm adherence to the reporting framework in preparation of this Performance Report.

Signed..

Chief Executive

Date: 28th June 2021

05 Accountability Report

The purpose of this Accountability Report is to meet our key accountability requirements to Parliament.

The Accountability Report has three elements:

- A Corporate Governance Report
- A Remuneration and Staff Report
- The Independent Auditor's Report to the Directors of Dudley Integrated Health and Care NHS Trust.

Corporate Governance Report

This Corporate Governance Report is a part of the Accountability Report, and is comprised of three sections:

- The Directors' Report (which includes the Statement of Directors' Responsibilities in Respect of the Accounts)
- The Statement of the Chief Executive's Responsibilities
- The Annual Governance Statement.

The Directors' Report

This Directors' Report is part of the Corporate Governance Report, and is set out under the following headings:

- The Trust Board – sets out the composition of our board, and relevant information about the individuals who were directors of the Trust during 2020/21.
- Board Assurance Committees – describes the Assurance Committees which support the Board.
- Board Effectiveness – the key findings of our Board Effectiveness Review.
- Statement of Directors' Responsibilities in Respect of the Accounts.

The Trust Board

Accountable to the Secretary of State, the Board is responsible for the effective direction of the affairs of the Trust, setting the strategic direction and appetite for risk. The Board establishes arrangements for effective governance and management as well as holding management to account for delivery, with particular emphasis on the safety and quality of the Trust's services and achievement of the required financial performance as outlined in its Terms of Reference.

The business to be conducted by the Board and its committees is set out in the respective Terms of Reference and underpinned by the Scheme of Delegation and Matters Reserved for the Board.

Our Trust Board meets formally every month in public session. Additional meetings with Board members and invited attendees are held following the public meetings to discuss confidential matters.

The Trust Board also holds confidential seminar (briefing) meetings /workshops every other month. All Non-Executive Directors take an active role at the Board and board committees.

Whilst our established and existing governance infrastructure continued throughout the pandemic, we did proactively consider items being reported to ensure appropriate oversight of risk and held virtual Committee and Board meetings to comply with social distancing guidelines.

Our Executive Team has delegated authority from our Board for the operational and performance management of clinical and non-clinical services of the Trust.

The Board is comprised of a Chair, five other Non-executive Directors (including a Deputy Chair and a Senior Independent Director (SID)), three Associate Non-Executive Directors, five Executive Directors, and an Associate Executive Director.

All Board members have been assessed against the requirements for the Fit and Proper Persons Test and together they bring a wide range of skills and experience to the Trust enabling us to achieve balance at the highest level. The structure is statutorily compliant and considered to be appropriate. The composition, balance of skills and experience of the Board is reviewed annually by the Appointment and Remuneration Committee.

Our Board members' roles and skills are summarised below.

Trust Board members 2020/21

Non-Executive Directors	
 Harry Turner, Chair Appointed on 1st April 2020 Chair of: • Trust Board • Trust Board Appointment and Remuneration Committee • Transaction Committee	Harry has extensive experience, having served as a Non-Executive Director and then Chairman of Worcestershire Acute NHS Trust between 2008 and 2016. He also took up the position of Chairman of the John Taylor Hospice in Birmingham October 2016 and was also a Non-Executive Director on Dudley and Walsall Mental Health NHS Trust. Harry has also been a Justice of the Peace in Worcestershire Courts for more than a decade. He previously worked as an Operations Director in the hotel industry, working for businesses including Travel Inn and Marriott International.
 Ian Buckley, Deputy Chair and Senior Independent Director Appointed on 1st April 2020 Chair of: • Finance, Performance and Digital Committee Member of: • Trust Board Appointment and Remuneration Committee • Quality and Safety Committee • Transaction Committee • Primary Care Integration Committee	Ian has worked as Chief Executive for a number of UK and US businesses and served on both PLC and private company boards. He trained as an engineer in Birmingham, moved into finance and leasing and became the UK Chief Executive of the US leasing giant GELCO (Now a division of GE). He was part of the management buyout and the subsequent public flotation at Evans Halshaw PLC serving as a main board director. In 1999 he joined Advanced Communication and Information Systems (ACIS) as CEO, a venture capital backed, telematics business specialising in providing real time passenger information for, airports, buses and trams. Whilst there, ACIS were awarded the Queens Award for Innovation. He was Deputy Chair and Non-Executive director of Birmingham Community Healthcare NHS Trust and Vice Chair of University Hospitals Coventry and Warwickshire NHS Foundation Trust. Currently he is a Business Angel investor, business coach and facilitator for Leadership Trust and guest lectures at Bristol Business School.

Non-Executive Directors

David Gilburt, Non-Executive Director

Appointed on 1st April 2020

Chair of:

- Audit and Risk Committee

Member of:

- Trust Board Appointment and Remuneration Committee
- Finance, Performance and Digital Committee

David Gilburt is a qualified accountant and has worked as Director of Finance in roles across the NHS at Health Authority, CCG, Trust and Regional level.

More recently he has worked as an independent consultant specialising in financial turnaround for NHS organisations in financial difficulty.

Valerie Little, Non-Executive Director

Appointed on 1st April 2020

Chair of:

- Quality and Safety Committee

Member of:

- Trust Board Appointment and Remuneration Committee
- Audit and Risk Committee
- Transaction Committee
- People Committee

Valerie was born and brought up in Dudley, attending school in the Borough. She has studied both science and social science at Bristol, LSE and Birmingham Universities. She worked for the NHS for 40 years – 18 of these as an Executive Director, finishing with 12 years as a Director of Public Health in Dudley. She is a Fellow of the Faculty of Public Health (FPH). She has served on the FPH Health Protection Committee and Housing Special Interest Group, as well as having acted as an FPH professional assessor. She served on the Executive Committee of the Association of Directors of Public Health, taking a lead on sexual health services. Over the years she has developed particular interests in health and regeneration; and the role that the Arts can play in health. Since retiring from full-time employment she has undertaken some independent public health work but now devotes time to her role as Vice Chair of the Corporation of Dudley College of Technology and Member of the Board of Care & Repair England. Valerie is both a resident and patient in the Borough.

<table>
<tr><th colspan="2">Non-Executive Directors</th></tr>
<tr><td>

George Solomon, Non-Executive Director

Appointed on 1st April 2020

Chair of:

- Primary Care Integration Committee

Member of:

- Trust Board Appointment and Remuneration Committee
- Quality & Safety Committee
- People Committee
</td><td>
George is a retired GP who worked in general practice for thirty-one years. He graduated from Glasgow University in 1978 and worked in Junior Doctor posts in Glasgow and Somerset.

He completed his GP training in Taunton and then moved to a GP Partnership in Tipton in 1985. His practice population of around 13,000 were made up of Sandwell and Dudley residents, which resulted in gaining experience in cross border working and forging relationships with colleagues in the local systems.

He has served as a Non-Executive Director of Sandwell Health Authority, a member of Sandwell PCT Professional Executive Committee and then as a GP member of Sandwell and West Birmingham CCG Governing Body with a lead for commissioning, where he championed the voice of local people and the need for joined up health and care services.

Over the span of his career he has been committed to ensuring patients receive integrated care and led initiatives to integrate practice and community nursing services within the practice, led the development of a Case Management Team to co-ordinate services for patients with complex needs and a joint Health & Social Care Team with agreed pooled resources.
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Martin Evans, Non-Executive Director

Appointed on 1st April 2020

Chair of:

- People Committee

Member of:

- Trust Board Appointment and Remuneration Committee
- Audit and Risk Committee
- Finance, Performance and Digital Committee
- Transaction Committee
</td><td>
Martin has worked within the public sector for over 30 years and has recently retired from the Police Service where he served latterly as an Assistant Chief Constable with West Mercia Police having responsibility for delivery of 24/7 policing services across the counties of Shropshire, Telford, Worcestershire and Herefordshire. He was the national policing lead for Collision Investigation and led on many developments and operations both nationally and across Europe in relation to roads policing, targeting travelling organised criminals whilst at the same time striving to make our roads safer and reduce the number of people killed and seriously injured.

Martin has many years of experience working at an operational and strategic level with other partner agencies including within the health service.

Martin is a people person, having previously and continuing to support others in a coaching and mentoring capacity and he is a great believer in wanting and needing to ensure that we do all that we can to look after and support our staff.
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Executive Directors	
 Paul Assinder, Chief Executive Appointed on 1st April 2020 Chair of: • Equality, Diversity and Inclusion Committee Attendee of: • Quality and Safety Committee • Finance, Performance and Digital Committee • Transaction Committee • Trust Board Appointment and Remuneration Committee	Paul is responsible for delivering the strategic and operational plans of the Trust through the Executive Team. Paul is one of the most experienced and respected Chief Financial Officers currently working in healthcare in the UK. He was elected as National President of the Healthcare Financial Management Association (HFMA), the leading professional body for finance staff working in UK healthcare, in December 2009. Doubly qualified as an accountant, with a University background in both economics and management, he trained and worked with Ernst & Young Co in the UK after graduation before specialising in the healthcare and technology sectors.
 Stephanie Cartwright, Interim Director of Operations, Strategy and Partnerships and Deputy Chief Executive Appointed on 1st April 2020 Attendee of: • Quality and Safety Committee • Finance, Performance and Digital Committee • Transaction Committee • Primary Care Integration Committee • People Committee • Equality, Diversion and Inclusion Committee	Stephanie is responsible for the operational management of the services within the Trust, and is the executive lead for strategy development and partnership working. Stephanie also has responsibility for strategic organisational development. Stephanie has responsibility for the day to day operation of our organisation and services, the development of our organisational strategies and for managing our relationships with our partners and stakeholders. Stephanie has over 25 years' experience of working with the Health Service. Her professional background is in organisational development, management and leadership and she has held a Board level role for eight years. For the last five years, Stephanie has been involved in the development of the ICP new care model in Dudley as the Programme Director, and more latterly as the Interim Managing Director for the ICP development; a role she has undertaken for the last 18 months. Stephanie is passionate about the transformational change that the ICP will bring to the way health and care services are delivered in Dudley and the opportunities that it will bring for both patients and staff alike.

Executive Directors	
 Chris Weiner, Interim Medical Director (In post May 2020 – March 2021) Attendee of: • Quality and Safety Committee • Transaction Committee • Primary Care Integration Committee • People Committee	During 2020/21 Chris was responsible for the performance and standards including service user safety. He was the Trust's named Caldicott Guardian. Chris has extensive experience across the health and care systems with 22 years with a background in Public Health. He has successfully transformed and driven improvement in health outcomes across public health, primary care, community and long-term condition services. His approach is outcome focused, evidence informed, data driven and developed with sustainable systems and processes in place. Before his time at Dudley Integrated Health and Care NHS Trust, Chris worked as Associate Medical Director at NHSE/I for three years. Other experience has included working as a non-executive director in an acute trust, the interim provision of Director Public Health and Director of Adult Social Care and Clinical Director within a new start up community provider.
 Caroline Brunt, Interim Director of Nursing, Allied Health Professionals (AHPs) and Quality Appointed on 1st April 2020 Attendee of: • Quality and Safety Committee • Transaction Committee • Primary Care Integration Committee • People Committee	Caroline is responsible for the professional standards, education and development of nursing and allied health professionals and leads on clinical governance. She is also the Lead Executive responsible for service user and public engagement, safeguarding and infection, prevention and control. Caroline commenced training as a nurse at the Queen Elizabeth Hospital, Edgbaston, Birmingham in 1981, registering in 1984. She subsequently qualified as a midwife in 1986 and has since continued her service in the NHS as a nurse/midwife working in a range of clinical and managerial roles throughout her career. She holds an NMC registration on both the adult nursing and midwifery registers. She also holds an MSc (Distinction) in Leadership and Management in Health and Social Care from the University of Southampton. Caroline has held senior clinical leadership posts prior to joining Dudley Clinical Commissioning Group (CCG) as Chief Nurse in November 2015. She leads the Quality and Safety team and the Safeguarding team; working together to ensure that DIHC meets its statutory responsibilities associated with the provision of safe, high quality patient services across the borough of Dudley. Caroline has also led the CCG Primary Care Commissioning team with oversight of the Primary Care core contracting and commissioning function.

Executive Directors	
 Matthew Gamage, Interim Director of Finance, Performance and Digital Appointed on 1st April 2020 Attendee of: • Audit and Risk Committee • Finance, Performance and Digital Committee • Transaction Committee • Primary Care Integration Committee • People Committee	Matt is responsible for the financial management of the Trust, as well as leading on contracting, performance and digital. He is named as the Senior Information Risk Owner. Matt is local resident with 25 years' experience in NHS Finance. Since 2013, he has been in the role of Head of Financial Management at Dudley CCG and has led on the financial development of the Integrated Community Provider and the new ICP contract. He is looking forward to implementing the new model of care and working with wider system to improve care for Dudley residents.

Since March 2021 and up to the date of this Annual Report and Accounts, the post of Medical Director has been jointly covered on an interim basis by Dr Richard Bramble and Dr Lucy Martin, the Trust's Associate Medical Directors.

Other Directors and persons attending Board regularly during 2020/21

- Bev Edgar, Associate Director of People: Attended 11 out of 12 Board meetings in 2020/21.
- Gillian Love, Associate Non-Executive Director: Attended 11 out of 12 Board meetings in 2020/21.
- Ruth Tapparo, Associate Non-Executive Director: Attended 6 out of 7 Board meetings in 2020/21.
- Stephen Cartwright, Associate Non-Executive Director: Attended 2 out of 2 Board meetings in 2020/21.
- James Young, Associate Director of Governance and Quality and acting Board Secretary to 31st December 2021: Attended 12 out of 12 Board meetings in 2020/21.
- Elaine Doyle, Trust Secretary from 1st January 2021: Attended 3 out of 3 Board meetings in 2020/21.

Register of Interests

The Board of Directors is satisfied that the Non-Executive Directors, who serve on the Board for the period under review, are independent, with each Non-Executive Director self-declaring against a 'test of independence' on an annual basis. The Board of Directors are also satisfied that there are no relationships or circumstances likely to affect independence and all Board members are required to update their declarations in relation to their interests held in accordance with public interest, openness and transparency.

The Trust Board has signed up to the Code of Conduct and Fit and Proper Persons Policies setting out the requirement for all Board members to declare any interests that may compromise their role. This is also a standing item at the beginning of each Board and Committee meeting. A Register of Director's Interests is published on the Trust website **https://www.dihc.nhs.uk/publications/board-papers/50-dudley-ihc-board-declaration-of-interest-register**.

Board Effectiveness

The Board of Directors keeps its performance and effectiveness under on-going review. The Board holds seminar and workshops every month to focus on educational, developmental and strategic topics. Examples of educational sessions in year include a NHS Improvement briefing on 'Plot the Dots' (Statistical Process Control, SPC and data analysis).

As a newly formed Board it has been taking part in a developmental programme facilitated by The Kings Fund. External expertise has been used to support delivery where necessary.

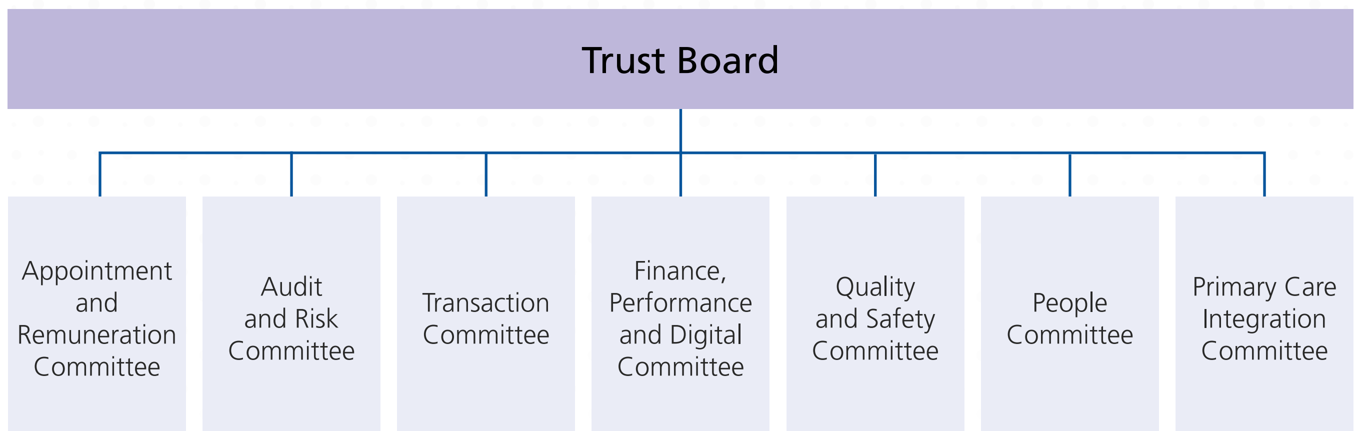
Individual Board members are appraised annually.

Board Assurance Committees

Trust Board Assurance Committees

The Board delegates certain functions to committees with the Board receiving terms of reference, committee self-assessments and annual reports. The Non-Executive Director Chairs of the assurance committees submit reports to the unitary board and minutes of the committees are shared. The Board met regularly to consider and discuss how the committees effectively share responsibility for monitoring strategic risk and the remit of their committees to avoid duplication.

At 31 March 2021 the Board Committee Structure was as described below.



DIHC currently attend the Black Country Healthcare NHS Foundation Trust Mental Health Legislation Committee.

Board Effectiveness Review

Trust Board Meetings

We conducted an internal evaluation of the Board and its key Committees in year, the outcomes of which help drive changes and improvements. The Board acknowledges the requirements of the NHSI and CQC 'Developmental reviews of leadership and governance using the Well- Led Framework: guidance for NHS Trusts and NHS Foundation Trusts' to conduct an independent assessment and will do so within 2021/22 well within the prescribed timeframe. This decision has been made in consideration of our future substantive Board appointments.

In addition, an annual governance review is conducted by each Board committee with plans to complete a mid-year review, in October 2021, against its agreed annual objectives, and at year end.

Report of the Audit and Risk Committee

Frequency of meeting: At least quarterly (plus private meeting with External Auditor).

During 2020/21 the committee met eight times and separately in private. One informal meeting took place to walk through the year end accounts and this was reported to public board.

The purpose of the Audit & Risk Committee is to provide one of the key means by which the Board of Directors ensures that effective internal control arrangements are in place. The Committee operates in accordance with Terms of Reference set by the Board, which are consistent with the NHS Audit Committee Handbook.

All issues and minutes of these meetings are reported to the Board. In order to carry out its duties, Committee meetings are attended by the Chief Executive, the Chief Finance Officer and representatives from Internal Audit, External Audit and Counter Fraud on invitation. The Committee directs and receives reports from these representatives, and seeks assurances from Trust officers.

The Committee's duties can be categorised as follows:

- Risk Management and Internal Control.
- Internal Audit.
- External Audit.
- Other Assurance Functions – including Counter Fraud.
- Financial Reporting.

In year the Committee has received progress reports against recommendations identified by Internal and External Auditors, committee specific health sector updates, and received updates on financial governance processes, including waivers, single tenders, Information Governance, Freedom to Speak Up and counter fraud investigations.

No significant issues in relation to the financial statements of 2020/21, operations or compliance were raised by the Audit and Risk Committee during the year.

The committee self-assessment rating was strong.

External Audit Services

Our External Auditors are Grant Thornton UK LLP, The Colmore Building, 20 Colmore Circus, Birmingham, West Midlands, B4 6AT.

The main responsibility of External Audit is to plan and carry out an audit that meets the requirements of The Code of Audit Practice and the National Audit Office.

External Audit is required to review and report on:

- Our financial statements (our accounts) and
- Whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources through the Value for Money audit programme.

The Audit and Risk Committee reviews the external audit annual audit plan at the start of the financial year and receives regular updates on progress. Expenditure recognised with Grant Thornton UK LLP for the period for was £64,000 and this was wholly in respect of the statutory financial statements audit.

Our external auditors did not conduct any non-audit services in year.

Internal Audit Services

Our Internal Auditors during 2020/21 were CWAudit.

Internal Audit provides an independent assurance with regards to our systems of internal control to the Board.

The Audit and Risk Committee considers and approves the internal audit plan and receives regular reports on progress against the plan, as well as the Head of Internal Audit Opinion which provides an opinion on the overall adequacy and effectiveness of the Trust's risk management, control and governance processes.

The Committee also receives and considers internal audit reports on specific areas, the opinions of which are summarised in the Annual Governance Statement.

The cost of the internal audit provision for 2021/21 was £51,200.

Committee Effectiveness and report of each of the Board Committees

Committee composition and attendance 2020/21 is summarised in the following section and in the table.

The Trust Secretary undertook a formal review of the effectiveness of the Board Committees during 2020/21. Key findings were:

Committee	Brief Summary
Quality and Safety	Frequency of meeting: Monthly During 2020/21 the committee met 7 times The Quality & Safety Committee is a non-statutory Committee established by the Trust Board to monitor, review and report to the Board on the quality of care to the Trust's patients, specifically in relation to patient safety, clinical effectiveness and patient experience, within the framework of the Board's agreed Five Facet approach to quality. In year the Committee received additional reports on a variety of matters, including oversight of transfer of services action plans, quality risks associated with the Board Assurance Framework and operational risks and papers were noted for awareness of quality related developments within wider system working. Internal Audit recommendations were received for oversight and to ensure appropriate action delivery. Rating - Adequate
Finance, Performance and Digital	Frequency of meeting: Monthly During 2020/21 the committee met 7 times The Finance, Performance & Digital Committee is a non-statutory Committee established by the Board to provide assurance to the Board on the delivery of the financial aspects of the Trust's annual Operating Plan, including financial strategy and planning, transformation and sustainability, the financial performance of the Trust, and on commercial and procurement activity and contracts, strategic investments and the development of the Trust's digital and estates infrastructure. In year the Committee received additional reports on a variety of matters, including oversight of transfer of services digital safe landing plans, financial risks associated with the Board Assurance Framework and operational risks and papers were noted for awareness of finance and digital related to the transaction and staff and service transfers. Rating - Adequate

Committee	Brief Summary
People	Frequency of meeting: Monthly During 2020/21 the committee met 8 times The People Committee is a non-statutory Committee established by the Board to monitor, review and report to the Board on the Cultural and Organisational Development of the Trust, and on the strategic performance of people and workforce priorities including the impact of the Trust as a significant employer, educator and partner in health and care. This committee endeavours to ensure a more systematic and intentional action is taken to tackle the underlying causes of health and workforce inequality and will prioritise action to tackle racism and discrimination experienced by staff across the NHS. It will ensure that Staff Experience is a key priority and ensure that the Trust is a Great Place to Work. In year the committee has received papers outlining a coordinated strategic response to the workforce needs of the organisation and the delivery of the Trust's strategic objectives in relation to "People". It ensured that there is an appropriate response to the strategic workforce risks and performance against workforce standards and key performance indicators. Rating - Adequate
Transaction	Frequency of meeting: Monthly During 2020/21 the committee met 11 times The Transaction Committee is a time limited non-statutory Committee established to oversee and report to the Board on progress against the legal, regulatory, and contractual processes of the series of transactions and transference of services to the Trust in line with the Strategic Case, Addendum to the Strategic Case, and the series of Business Cases. In year the committee provided assurance to the Board in relation to transaction governance, operational mobilisations and considered several papers on wider strategic matters, escalating risks to other committees and to the Board as appropriate. Rating - Strong

Committee	Brief Summary
Primary Care Integration	Frequency of meeting: Bi-Monthly During 2020/21 the committee met 6 times The Primary Care Integration (PCI) Committee is a non-statutory Committee established to oversee and report to the Board on development of the strategy for PCI, consideration of the role of the Primary Care Networks (PCN) in delivery of the DES and Local Improvement Schemes (LIS) and the provide assurance to the Trust Board as to how the Integration Agreement between the Trust and the GP Practices is managed; and resources are being used to support the provision of primary care services in Dudley and realise the integration activities and goals as set out in the Integration Agreement. In year the committee has developed a co-produced workplan and committed to bi-monthly development sessions to facilitate and grow the relationship between the Trust and the primary care networks. Terms of Reference and committee effectiveness review will be undertaken at half -year in recognition of the development stage of the committee.
Appointments and Remuneration	Frequency of meeting: Bi-Monthly During 2020/21 the committee met four times The purpose of the Committee is to determine the appropriate remuneration and terms of service for the Chief Executive and other Executive Directors, including all aspects of salary (including any performance-related elements / bonuses), provisions for other benefits, including pensions and annual leave allocations at variance with standard NHS terms and conditions; and arrangements for termination of employment and other contractual terms. In year the committee has advised the Board on appropriate pay and terms of service for all Board level posts, excluding the Chair and Non-Executive Directors whose pay and terms of service are set by NHS Improvement (NHSI).

An **Integrated Governance Committee** was in existence from April 2020 until August 2020, and combined a number of assurance activities across the areas of workforce, quality and safety and finance, performance and digital. From August 2020 the Board Committee structure developed and separate Quality & Safety, Finance Performance and Digital, People, and Primary Care Integration Committees were in place.

The **Executive Committee** started formally in January 2021, with the purpose of the Committee to assist the Chief Executive in the performance of their duties, including:

- setting the direction of travel for the organisation through making major strategic and operational decisions not reserved to the Board;
- proposing and refining of issues and recommendations on matters reserved to the Board;
- providing assurance that clinical and operational scrutiny has been properly discharged;
- the development and implementation of business strategy and associated operational plans;
- the monitoring of operating and financial performance;
- the assessment and control of risks, other than those relating to safety and quality of services; and
- the prioritisation and allocation of resources.

The Committee meets on a weekly basis and is the Executive Directors plus Associate Director of Governance and Quality and the Head of Communications.

The **Trust Management Board** operates as the Trust's 'Strategic and Operational Board' and oversees all day-to-day matters of operational, strategic and corporate significance. It is chaired by the Chief Executive, and the other substantive members are the Director of Finance, Performance and Digital, the Medical Director, the Director of Operations, Strategy and Partnerships, the Director of Nursing, the Associate Director of People, the Associate Director of Governance and Quality, Heads of Services, the Chief Pharmacist, the Head of Primary Care and the Head of Communications. The Committee meets on a monthly basis.

Information governance incidents

DIHC have had no Information Commissioners Office (ICO) reportable incidents within 2020/21. Information Governance Incidents are monitored and reviewed by the Trust's Information Governance Group which reports any high risk incidents to Finance and Performance Committee.

Further information can be found within the Annual Governance Statement.

Attendance by members of Board Committees in 2020/21

The below figures indicate the number of meetings attended by the relevant member/total number of meetings held during 2020/21.

Board Member	Trust Board Part 1	Trust Board Part 2	Audit and Risk Committee	Appointments and Remuneration Committee	Integrated Governance Committee*	Quality and Safety Committee	Finance, Performance and Digital Committee	People Committee	Transaction Committee	Primary Care Integration Committee
Harry Turner	12/12 (100%)	12/12 (100%)		5/5 100%	5/5 (100%)				8/11 (72.7%)	
Ian Buckley	12/12 (100%)	12/12 (100%)		5/5 100%	5/5 (100%)	7/7 (100%)	7/7 (100%)		11/11 (100%)	6/6 (100%)
David Gilburt	11/12 (92%)	11/12 (92%)	7/8 (87.5%)	3/5 60%	5/5 (100%)		7/7 (100%)			
Valerie Little	11/12 (92%)	11/12 (92%)	8/8 (100%)	5/5 100%	5/5 (100%)	7/7 (100%)		8/8 (100%)	10/11 (90.9%)	
George Solomon	12/12 (100%)	12/12 (100%)		5/5 100%	5/5 (100%)	7/7 (100%)		6/8 (75%)		6/6 (100%)
Martin Evans	12/12 (100%)	12/12 (100%)	6/8 (75%)	4/5 80%	4/5 (80%)		6/7 (85.71%)	8/8 (100%)	11/11 (100%)	
Paul Assinder	12/12 (100%)	12/12 (100%)		3/5 60%	5/5 (100%)	5/7 (71.4%)	6/7 (85.71%)		8/11 (72.7%)	
Stephanie Cartwright	12/12 (100%)	12/12 (100%)			5/5 (100%)	6/7 (85.7%)	6/7 (85.71%)	8/8 (100%)	11/11 (100%)	6/6 (100%)
Dr Chris Weiner	11/12 (92%)	11/12 (92%)			3/4 (75%)	7/7 (100%)		3/8 (37.5%)	9/11 (81.8%)	5/6 (83%)
Caroline Brunt	12/12 (100%)	12/12 (100%)			5/5 (100%)	7/7 (100%)		8/8 (100%)	6/11 (54.5%)	5/6 (83%)
Matt Gamage	12/12 (100%)	12/12 (100%)	8/8 (100%)		5/5 (100%)		7/7 (100%)	4/8 (50%)	11/11 (100%)	5/6 (83%)

**The Integrated Governance Committee was in existence from April 2020 until August 2020, from which point the Board Committee structure developed and separate Quality & Safety, Finance Performance and Digital, People, and Primary Care Integration Committees were in place.*

The statement of Directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts and knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that they ought to have taken" to make themselves aware of any such information and to establish that the auditors are aware of it.

The directors 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 Trust's performance, business model and strategy.

By order of the Board

Signature ....Chief Executive

Date: 28th June 2021

The statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer and, as far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that DIHC auditors are aware of that information.

Signed..Chief Executive

Date: 28th June 2021

Annual Governance Statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS 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 Trust Accountable 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 Dudley Integrated Health and Care NHS 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 Dudley Integrated Health and Care NHS Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

The integrated governance framework

Within the Directors Report Section of this Annual Report outlines the governance committee structure, the key responsibilities of the committees as well as the following information:

- The individuals who serve on the Board.
- Changes in appointments.
- Attendance records at Board and Committees meetings.
- Committee reports and effectiveness review findings.

A summary of the role of the Audit & Risk Committee is found within the Directors Report section of the Annual Report.

During the year internal auditors provided a range of individual opinions arising from the risk-based audit assignments that have been reported throughout the year. The internal audit plan for 2020/21 was developed to provide independent assurance on the adequacy and effectiveness of systems of control across a range of financial and organisational areas. To achieve this the internal audit plan was divided into two broad categories; work on the financial systems that underpin financial processing and reporting and then broader risk focused work driven essentially by principal risk areas that had identified in through the Trust Board Assurance Framework.

Rating	Internal Audit
Significant Assurance	• Conflict of Interest. • Financial Governance – during COVID-19. • Quality Framework – Development. • Key Controls – Financial Systems. • High Oak Surgery – Health Check.
Moderate Assurance	• Key Controls - Payroll. • Data Quality – % Patients with depression and/or anxiety who enter IAPT. • Data Security and Protection Toolkit (DSPT).
Other	• Board Assurance Framework – Level A. • COVID-19 – Governance Review. • Continuing Healthcare – Self Assessment.

Significant progress has been made in respect of responding to recommendations made by our internal auditors, as reflected within their Head of Internal Audit Opinion of significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

However, we do recognise some weakness in the design and/or inconsistent application of controls, including:

- Payroll – we were unable to provide evidence that the payroll is reviewed and formally authorised prior to release by the outsourced NHS provider, it was recognised that the payroll at the Trust is currently small and manageable and is reviewed at several stages. This has now been rectified.
- Data Quality - Information for internal reporting had been provided by Black Country Healthcare NHS Foundation Trust (BCH) as part of a Service Level Agreement. The key issue noted in this data quality review was in relation to the current internal reporting which does not satisfy the requirements of this national indicator. The national requirements are that a local prevalence denominator is used, instead the Trust was using a locally agreed trajectory which produces a significantly higher compliance rate. The correct performance has now been retrospectively calculated by the Trust.
- COVID-19 – The review highlighted that the Trust had responded well to the challenge of achieving governance during the pandemic. However it was noted that the EPRR (Emergency Preparedness, Resilience and Response) arrangements, which are outsourced through a Service Level Agreement to BCH, that an assurance letter citing EPRR arrangements, required from all NHS bodies to be submitted to NHSE by 31st October 2020, was not completed.

The Board has an agreed annual cycle of business and receives exception reports via the relevant Chair in relation to recent meetings of its committees. The Board, as a standing item at each meeting, also considers whether additional assurance is sought from its committees on any items of concern.

The Board considers commentary on significant changes recorded in the Board Assurance Framework (BAF) and Corporate Risk Register at each public meeting and each Board Committee also considers relevant BAF risks and progress against internal audit recommendations at each meeting.

Progress on corporate and strategic objectives is reported quarterly within the performance report. In addition, a number of internal audits were completed, as described previously and annually each Board Committee presents an annual report to the Board detailing a summary of business transacted and achievements against the agreed Committee objectives.

The Committee annual effectiveness reports are available via the Public Board papers on our website. Further details of the Board's development activities and performance evaluation can be found within the Directors Report section of the Annual Report.

We self-certify against the requirements of the NHS Provider Licence to ensure on-going compliance, in accordance with the NHSI Single Oversight Framework requirements (including Conditions G6 and FT4) – the details of which are incorporated into our Board Performance Report and publicly available.

We do not consider there to be any principal risks in relation to compliance with the requirements of the Licence requirements.

Capacity to handle risk

As Chief Executive, I am ultimately accountable for governance and risks relating to the operational delivery of all clinical and non-clinical services provided by the Trust including its subcontracts.

The Board regularly considers its risk appetite and reviewed this together with its risk tolerance during the year. Details can be found within our Board Assurance Framework and Risk Management Strategy (available via our website). The appetite and tolerance sets the parameters of Risk Management for staff to operate within. The Board is informed of current risks and regular reporting of the Board Assurance Framework at its public board and through assurance committee assurance reports.

The Trust has a range of arrangements in place which provide monitoring and assurance on matters relating to quality, safety and regulatory matters. Each service has a governance structure in place which reports through to the Quality & Safety Steering Group though to the Quality & Safety Committee.

Corporate Services have governance structures in place to report through to their appropriate Board Committee.

Key roles in relation to risk management and quality governance include:

Title	Role / Responsibility
Chief Executive	As Accountable Officer has overall responsibility for the Trust's risk management programme and for ensuring that this system operates effectively and that there is a sound system of place to manage risks within the organisation.
Medical Director	Responsible for maintaining effective governance arrangements which support the appropriate escalation and management of risks within the clinical divisions and service treams, including risks surrounding medication management, pharmacy, etc. The Medical Director also acts as the Trust's Caldicott Guardian. It is the role of the Caldicott Guardian to be responsible for the oversight of the arrangements in that organisation for the use and sharing of clinical information.
Director of Nursing, Allied Health Professionals and Quality	The designated Board member with overall responsibility for the Trust's organisational risk management systems, the Trust's Clinical Governance arrangements and is responsible for ensuring that there are sufficient resources directed to ensuring they are appropraitely managed and mitigated.
Director of Operations	Responsible for ensuring the Trust's Health and Safety and operational risks held by the Trust's clinical teams are appropriatly managed and there are sufficient resources directed to ensuring these risks are appropraitely managed and mitigated.
Director of Strategy, People and Partnerships	Responsible for ensuring that interagency risks and risks associated with partnership working are shared with other organisations and the future strategic direction of the organisation are appropriately mitigated. In addiiton, holds the responsibility for ensuring risks within the People Directorate are appropriatly managed and there are sufficient resources directed to ensuring they are appropraitely managed and mitigated.
Director of Finance, Performance and Digital	Responsible for advising the Trust Board on all aspects of financial risk ensuring effective mechanisms are in place to manage the and is also the Trust's Senior Information Risk Officer (SIRO). It is the role of the SIRO to take ownership of the organisation's information risk policy.
Trust Secretary and Associate Director of Governance, Quality and Risk	Retains the delegated responsibility for the development of the Trust's risk management strategy and for the development of key policies and procedures around risk management. They are also responsible for integrating these risk management systems with other clinical governance processes.

Title	Role / Responsibility
Governance Manager	Ensures the day to day running of the Trust's Risk Processes within the organisation and has the delegated responsibility to ensure that the Trust's approach to risk management is robust and complies with best practice and that risk management systems are maintained to manage risk effectively. It is also their role to prepare a number of 'risk reports' for appropriate committees to faciloatate the Chair in the execution of their duties as defined within the Board Committee Terms of Reference.
Heads of Service / Divisional Management	It is the role of divisonal management to ensure that routine reviews of all divisional / service risks are completed, in collaboration with their respective Heads of Nursing / AHPs / Heads of Service. Ensuring that all divisional / Service high level risks are routinely reviewed and escalated according to the internal governance processes and risk management and assurance framework.
All Staff	Management of risk is a fundamental duty of all staff. All staff must ensure that identified risks and incidents are reported in order to ensure appropriate actions are taken. These requirements also extend to agency staff.
Partner Organisations and Contractors	Specific risks identified in the Trust will be shared with any other relevant organisation working in partnership with the Trust.

The Trust adopts a structured and pragmatic approach to risk management training and provides a comprehensive programme of risk management training.

Training on utilising the risk and incident management system will be provided by RLDatix who will provide training to individuals identified as being responsible for managing risks on the Trust's risk management system.

All board members and senior managers will undergo specialist risk management training as a mandatory requirement. This will be supported by a programme of different platforms and formats.

Trust wide arrangements which support robust assurance include:

- The Board and Committees are appraised of the key risks at each meeting support by risk based agendas that are embedded throughout the Trust from Board, committees, steering groups and divisional operational meetings. This has ensure every manager remains responsible for the oversight of quality and risks, triangulating performance information to monitor and address service quality at all levels. These divisional meetings provide exception reporting to the Quality and Safety Steering Group which is chaired by the Medical Director and these are then scrutinised at the Quality and Safety Committee. The service line structure provides high levels of autonomy increasing the effectiveness and accountability of the services. The roles of the Quality Assurance Committee and Audit and Risk Committee are described previously.
- Oversight of performance and risk by the Executive Team via daily escalation and reporting through to the weekly Executive Committee.
- Contract, Quality & Risk Management Meeting (CQRM) – monthly monitoring with commissioners.
- Visits by the Board and senior leadership team engaging with staff and service users.
- Learning from serious incident reviews.
- Trustwide and service level covering standards and topic specific issues.
- Our Quality Account which outlines the progress made and action taken to improve and maintain quality and safety within and across Trust services. The first Annual Quality Account is under developed in consultation with key stakeholders and will serve as an additional validation mechanism for determining the quality of services.

The Board Assurance Framework (BAF) provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been identified and where gaps exist, that appropriate mitigating actions are in place to reduce the risk to a tolerable level. The Audit and Risk Committee tests the effectiveness of this system and will be reviewed annually.

The risk and control framework

I am assured that risk management processes are continuing to be increasingly embedded within the Trust and incident reporting is openly and actively encouraged to ensure a culture of continuous improvement and learning.

I am also assured that there are appropriate deterrents in place concerning fraud and corruption.

The organisation understands that successful risk management requires participation, commitment and collaboration from all staff.

The Board approved the Board Assurance Framework and Risk Management Strategy in January 2021 and provides a clear overarching framework for the management of internal and external risk and describes the accountability arrangements, processes and the Trust's risk appetite.

The Board took time in year to consider the Trust's risk appetite and tolerance and will review again early in 2021/22 as the Trust grows. The Trust's approach to risk management encompasses the breadth of the organisation by considering financial, organisational, reputational and project risks, both clinical and non-clinical.

This is achieved through:

- an appropriate framework; delegating authority, seeking competent advice and assurance;
- a risk culture which includes an agreed risk appetite, as outlined within the framework;
- the integration of risk management into all strategic and operational activities
- the identification and analysis, active management, monitoring and reporting of risk across the Trust ;
- the appropriate and timely escalation of risks;
- an environment of continuous learning from risks, complaints and incidents in a fair blame culture underpinned by open communication;
- consistent compliance with relevant standards, targets and best practice; and
- actively analysing and reflecting on key findings from our annual staff survey, staff friends and family test as well as intelligence and feedback from our friends and family feedback to ensure issues are addressed.

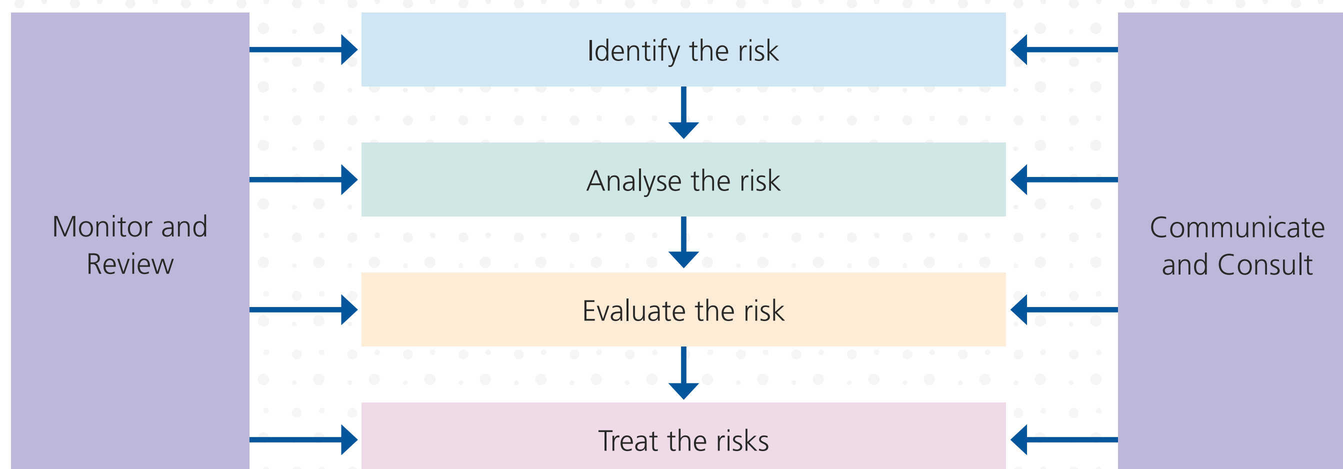
Fraud deterrence including the proactive work conducted by the Local Counter Fraud Service, supported by the 'Local Counter Fraud, Bribery and Corruption Policy'. Fraud deterrence is integral to the management of risk across the organisation especially as there could be clinical or health and safety implications which could then impact upon the organisation.

Staff are encouraged to report any potential fraud using the online incident reporting process appropriately including anonymous reporting if necessary. We are not aware of any specific areas within the organisation that are at risk of material fraud, however we cannot be complacent and continue to develop the proactive work in this area.

The Corporate Risk Register will be supported by the implementation of RLDatix module of risk management, the incident module has been implemented from 1st April 2021 and is now fully embedded and has provided the ability for real time reporting and escalation; it also aligns existing systems used for incident, complaints and claims reporting. The use of the online system supports the triangulation of data from incidents, claims and complaints for further analysis and assurance.

The Trust encourages a proactive safety culture, good communication and teamwork, all of which are inherent in the improvement of risk and the implementation of good clinical risk assessments. To ensure clinical risk assessments are appropriate they are always reviewed as part of all serious or high risk investigations so that lessons can be learnt and assessments improved if necessary. The positive risk management culture and risk management processes have enabled the Trust to proactively identify, assess, treat and monitor significant risks in year.

The diagram overleaf broadly outlines the Trust's processes and identifies that risk management involves the identification, analysis, evaluation and treatment of risk.



There is clear alignment between the Board Assurance Framework and operational corporate risk register and our risk report summarises the key risks and provides analysis of the changes are reported through the committees each month. Central to the robust and effective management of risk is the escalation of risks throughout the organisation to Executive Meetings and Board Committees. This is supported by a process of oversight and scrutiny by Management, Executives and Board Committees. Risks identified will be escalated in line with the framework outlined overleaf in the Risk Escalation Framework.

Divisional / Service Level / Programme and Projects

Risks scored 6 and above → Risk Registers

Risks scored 6 and above → Risk Registers

Risk Escalation

Corporate Risk Register (CRR)

Risks scored 15 and above → Corporate Risk Register (CRR)

Risks scored 15 and above → Corporate Risk Register (CRR)

Risk Escalation

Trust Board

Strategic Priorities Risks

Horizon Scanning

Board Assurance Framework (BAF)

Corporate Risk Register (CRR)

Compliance Risks

System Partners

STP Risks

Horizon Scanning

Partnership Risk Register

Compliance Risks

All new risks are entered onto team risk registers after discussions/challenge with Managers, Leads, and Heads of Service.

Risk owners are assigned and are responsible for managing the risk(s), implementing controls measures reviewing actions and reviewing the risk.

All risks will be owned by an Executive Director and will be monitored monthly by a nominated Board Committee to ensure that the management of the risk is effective and to allocate additional resources if required.

The Executive Team will determine which strategic risks should be escalated to the Board Assurance Framework (risks warranting Board attention), which provides the Board with a register of significant risks against the strategic objectives of the Trust and gives assurances that the risks are being managed effectively.

The Executive Team liaising with stakeholders will determine which risks will populate the Partnerships Risk Register.

The Trust uses the matrix below, rating likelihood and severity matrix to assign a risk score and we recognise that in all cases it is vital to set the risk into context for evaluation. We accept that risks which fall outside of the remit of routine clinical assessment or are potentially significant for the organisation are approached and managed in line with the BAF and Risk Management Strategy.

		Consequence				
		1. Negligible	**2.** Minor	**3.** Moderate	**4.** Major	**5.** Catastrophic
Likelihood	**1.** Rare	1	2	3	4	5
	2. Unlikely	2	4	6	8	10
	3. Possible	3	6	9	12	15
	4. Likely	4	8	12	16	20
	5. Almost certain	5	10	15	20	25

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

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

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

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken sustainability impact assessments and has a Sustainability and Net Zero NHS Strategy 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 and has committed to delivery of a three year Green Plan by March 2022.

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

As Accounting Officer, I am responsible for ensuring that the Trust has arrangements in place for securing value for money in the use of its resources. To do this I have maintained systems to:

- Set, review and implement strategic and operational objectives.
- Engage actively with patients, staff and other stakeholders to ensure key messages about services are received and acted upon.
- Monitor and improve organisational performance.
- Establish plans to deliver cost improvements.

The Trust submits to NHS Improvement (NHS I) an Annual Plan incorporating a supporting financial plan approved by the Board of Directors. This informs the detailed operational plans and budgets which are also approved by the Board. The Trust actively engages Commissioners, NHS Improvement and others as necessary to develop and agree detailed financial and operational plans. Prior to approval the Board takes the views obtained from stakeholders into account.

The Board agrees annually a set of corporate objectives and milestones which are communicated to colleagues. Achievement of those milestones is reviewed on a quarterly basis.

Operational performance is kept under constant review by the Executive Team and Board of Directors.

Standing Orders and Standing Financial Instructions including a scheme of delegations have been approved by the Board. These key governance documents include explicit arrangements for:

- Setting and monitoring financial budgets;
- Delegation of authority;
- Performance management; and
- Achieving value for money in procurement.

A financial plan approved and monitored by the Board.

The Trust operates a hierarchy of control, commencing at the Board and cascading downwards to budget managers in relation to budgetary control, balance sheet reconciliations, and periodic review of service level income with commissioners. In addition, the Finance, Performance and Digital Committee provides scrutiny and oversight which has been reviewed by internal audit.

Robust competitive processes used for procuring non-staff expenditure items and where the Trust has agreed procedures to override internal controls in relation to competitive tendering in exceptional circumstances and with prior approval obtained and is reported to the Audit and Risk Committee.

Strict controls on vacancy management and recruitment gaining assurance from the People Committee and the Finance, Performance and Digital committee on the adherence to theses mechanisms.

The Board gains assurance from the Quality Assurance Committee regarding the quality of services and compliance with regulatory control. The Audit & Risk Committee test the effectiveness of these systems.

Information governance

DIHC have had no Information Commissioners Office (ICO) reportable incidents within 2020/21. Information Governance Incidents are monitored and reviewed by the Trust's Information Governance Group which reports any high risk incidents to Finance and Performance Committee.

Data Security and Protection Toolkit

The Data Security and Protection Toolkit (DSPT) is based upon the National Data Guardian Standards. Unlike the previous Information Governance Toolkit the DSPT does not provide a score or rating of the assessment so the Trust either met, or did not meet the DSPT standard. The Trust submitted the Data Security and Protection Toolkit in March 2020 and reported that it met compliance with mandatory assertions. In addition to the mandatory assertions, the Trust met 15 of the non-mandatory requirements.

Relevant Data Security training is mandatory for all staff within the Trust in accordance with national information governance standards and the Trust reported below the 95% mandated standards, this is following the reduction of training provision to meet clinical needs throughout the pandemic, the Trust ensures that all new starters complete their mandatory training within Information Governance an Data Security and all staff have completed the training within the past 2 years. However 100% of the Trust's board has completed relevant Information Governance and Data Security Training. To balance the training compliance the Trust have regular IG communications sent to all staff and there are full actions plans in place to increase the training compliance across the Trust. Any incidents and/or risks associated with data and information security are reported and dealt with in accordance with the Trust risk management and incident reporting policies.

Due to the impact of COVID-19 the finalisation of the DSPT for 2020/21 is not set to be completed until June 2021. The Trust has monitored progress with the Data Security and Protection Toolkit closely and is on target to submit requirements met with action plans in place the actions plans are likely to be around staff training compliance, as this is currently below the 95% standard. The table below provides an overview of what the Trust submitted in relation to the DSPT:

2020/21	Completed	Items Not Met	% Complete
Mandatory Requirements	107	3*	97.27
Optional Requirements	39	3	92.86
Totals	146	6	95.89

*submitted the DSPT as Not Met with Action Plan in place

Internal Audit Opinion on Data Security and Protection Toolkit (DSPT)

A moderate assurance rating has been given following the internal audit against the evidence requirements set out by NHS Digital. Due to the timing of the annual report and accounts the audit recommendations are still being developed, the Trust will ensure implementation of the recommendations to strengthen the assurances and processes that support the assertions with the DSPT toolkit.

Cyber Security

Over the past 12 months there has been a close working relationship between the Trust and Dudley Group NHS Foundation Trust (IT Provider) which has embedded data protection by design linked with the IT function. The Trust has gained assurances from the IT Provider in relation to their ISO accreditation.

Data quality and governance

In relation to data quality and management, the Trust:

- Completes data flow mapping and has developed charts and risk assessments in relation to the data flows across the organisation as well as externally. Data flow mapping charts have been created in line with developments within the Trust in 2020-21.
- Has agreements in place for data quality with both the CCG and BCHFT, and gains assurances directly from each organisation.

Data quality features in our internal audit plan to provide assurance to the board that there are robust controls in place to ensure the accuracy of data.

Performance information relating to our mental health services is provided through a service level agreement with Black Country Healthcare NHS Foundation Trust (BCHFT). This information is subject to BCHFT data quality processes. For assurance purposes, DIHC included an IAPT data quality audit as part of the internal audit plan for 2020/21. The audit provided moderate assurance and subsequently a number of actions have been agreed to improve data quality in 2021/22 as part of the development of an in-house Business Intelligence function.

Review of effectiveness

As Accountable 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 Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in 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 and Risk committee, the Quality and Safety Committee and a plan and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The following key processes have been applied in maintaining and reviewing the effectiveness of the system of internal control:

- A review of committee effectiveness and governance arrangements by the Trust Secretary and the committee recommendations, with the Board responsible for approving and monitoring systems to ensure proper governance and the management of risk which will be supported by an independent Well Led review in 2021/22.
- Reviews of key governance documentation such as Standing Orders, Standing Financial Instructions and Scheme of Delegation and the Board Assurance Framework.
- The oversight by the Audit & Risk Committee of the effectiveness of the Trust's systems for internal control, including the Board Assurance Framework (BAF).

  In discharging their duties the committee takes independent advice from the Trust's internal auditors (CWAudit) and external auditors (Grant Thornton). The BAF is also reviewed and challenged by the Board and updates are presented by the Trust Secretary.
- The internal audit plan to address areas of potential weakness in order that the Trust can benefit from insight and the implementation of best practice recommendations and the findings of relevant internal audits as it develops systems of internal control.

The Head of Internal Audit Opinion (HOIA) concluded an opinion of 'significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk'.

It was noted however, that there are some areas of weakness and as such the Trust has now implemented and rectified the weaknesses on Payroll, Data Quality and in the EPRR assurances.

We are actively addressing all recommendations made by our auditors across all audits conducted and track progress with regular reports to overseeing Committees.

The HOIA also highlights areas of good practice including development of an effective Board Assurance Framework, recognising the development of the Trust and achieving significant assurance across the reviews and implementing all audit actions effectively.

Conclusion

I therefore believe that the necessary arrangements are in place for the discharge of statutory functions, that the Trust is legally compliant, that there are no irregularities and confirm no significant internal control issues have been identified.

In conclusion, and in acknowledgment of the referenced issues, supported by the Head of Internal Audit Opinion of 'significant assurance' I believe Dudley Integrated Health and Care NHS Trust has a generally sound system of internal controls that supports the achievement of its objectives.

Signed...Chief Executive

Date: 28th June 2021

Remuneration and Staff Report

This Remuneration and Staff Report is part of the Accountability Report. It comprises a Remuneration Report and a Staff Report. The elements which are subject to audit are clearly noted.

Remuneration Report

Remuneration Policy

Our Chair is appraised on an annual basis by NHSEI.

The Non-Executive Directors are appraised by the Chair of the Trust, as is the Chief Executive. These appraisals are done on an annual basis, including a 360 degree review. Following the appraisal, a summary of the appraisal outcomes is produced.

The other directors are appraised by the Chief Executive. The Appointment and Remuneration Committee have not determined any performance related pay arrangements or bonuses.

Our Appointment and Remuneration Committee is chaired by the Chair and includes other Non-Executive Directors. It is responsible for reviewing the terms and conditions of our most senior managers, including salary, pensions, termination and / or severance payments and allowances. The committee meets when required and attendance at meetings can be found within the Directors Report.

Any inflationary pay award for those Executive Directors on Very Senior Manager Contracts is determined under the guidance from NHSEI annually by the Appointment and Remuneration Committee.

For those Executive Directors on VSM contracts on secondment from the Clinical Commissioning Group (CCG) performance related pay arrangements or bonuses are determined by their employer.

Directors' Remuneration and Terms and Conditions

Senior Managers Remuneration

The Appointment and Remuneration Committee determines the remuneration for senior managers after taking into account NHSEI guidance, any variation such as changes to the responsibilities of the senior managers, benchmarking and market comparisons, job evaluation and weighting as well as applying any pay uplifts for other NHS staff by NHS pay review bodies.

The remuneration and terms and conditions for Directors who sit on the Board (except Non-Executive Directors) are set by the Appointment and Remuneration Committee. For all post holders (except those on secondment, who have retained the terms and conditions for their substantive posts) the remuneration and terms and conditions are in accordance with Very Senior Manager terms and conditions.

The Chief Executive's pay has been set using benchmark information for similar Chief Executive Positions in other comparable Trusts.

All Directors receive regular appraisals.

The following Directors are directly employed by DIHC on fixed term contracts of employment:

- Chief Executive
- Associate Director of People
- Associate Medical Directors

The following Directors are on interim contracts of employment including secondment agreements:

- Director of Nursing, AHPs and Quality
- Director of Operations, Strategy and Partnerships
- Director of Finance, Performance and Digital
- Medical Director

No termination payments have been made during the reporting period.

There are no other additional benefits that will become receivable by a senior manager in the event he/she retires early.

Remuneration report tables (Subject to Audit)

Single total figure table – 2020/21

Name Title Period of Office *(if not 01/04/2020 – 31/03/2021)*	**(a) Salary** (bands of £5,000) £000	**(b) Expense payments (taxable) total** (to nearest £100) £00	**(c) Performance pay and bonuses** (bands of £5,000) £000	**(d) Long term performance pay and bonuses** (bands of £5,000) £000	**(e) All pension-related benefits** (bands of £2,500) £000	**(f) TOTAL (a to e)** (bands of £5,000) £000
Harry Turner Chair	45-50	5	-	-	-	45-50
Paul Assinder Chief Executive (Interim)	85-90	-	-	-	-	85-90
Caroline Brunt Director of Nursing and Allied Health Professionals (Interim)	110-115	35	5-10	-	62.5-65	185-190
Matthew Gamage Director of Finance (Interim)	105-110	-	5-10	-	132.5-135	245-250
Stephanie Cartwright Director of Operations, Strategy and Partnerships (Interim)	110-115	-	5-10	-	127.5-130	245-250
Dr Chris Weiner Interim Medical Director	130-135	-	-	-	77.5-80	205-210
David Gilburt Non-Executive Director	10-15	-	-	-	-	10-15
Ian Buckley Non-Executive Director	10-15	-	-	-	-	10-15
Martin Evans Non-Executive Director	10-15	-	-	-	-	10-15
Dr George Solomon Non-Executive Director	10-15	-	-	-	-	10-15
Valerie Little Non-Executive Director	10-15	-	-	-	-	10-15

Medical Directors total remuneration and pension benefits in relation to clinical role was as follows:

- Dr Chris Weiner £145,000 - £150,000

Between 1 May 2020 and 31 March 2021, the services of Dr Chris Weiner as Interim Medical Director were provided under an agreement with NHS England and Improvement. The benefit paid to NHS England 1 April 2020 and 31 March 2021 in respect of these services was £147,000.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual.

The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Single total figure table – 2019/20

It should be noted that the table below relates to the time when the Trust was designated as Dudley and Walsall Mental Health Partnership NHS Trust.

Name Title Period of Office *(if not 01/04/2019 – 31/03/2020)*	**(a) Salary** (bands of £5,000) £000	**(b) Expense payments (taxable) total** (to nearest £100) £00	**(c) Performance pay and bonuses** (bands of £5,000) £000	**(d) Long term performance pay and bonuses** (bands of £5,000) £000	**(e) All pension-related benefits** (bands of £2,500) £000	**(f) TOTAL (a to e)** (bands of £5,000) £000
Harry Turner Chair *01/04/2019 – 30/06/2019*	5 – 10	9	-	-	-	5 – 10
Simon Murphy Chair *01/07/2019 – 30/09/2019* **Non-Executive Director** *01/04/2019 – 30/06/2019 and 01/10/2019 – 31/03/2020*	5 - 10	10	-	-	-	10 – 15
Mark Axcell Chief Executive	140 – 150	10	-	-	7.5 – 10.0	155 – 160
Robert Pickup Interim Director of Finance *01/11/2019 – 31/03/2020*	35 – 40	-	-	-	495.0 – 497.5	530 – 535
Marsha Foster Acting Director of Operations	100 – 105	-	-	-	7.5 – 10.0	110 – 115
Rosie Musson Acting Director of Nursing	100 – 105	-	-	-	-	50 – 55
Ashi Williams Acting Director of People	85 – 90	8	-	-	15.0 – 17.5	105 – 110
Dr Mark Weaver Medical Director	200 – 205	39	-	-	20.0 – 22.5	225 – 230
John Lancaster Non-Executive Director	5 – 10	18	-	-	-	5 – 10

Name Title Period of Office *(if not 01/04/2019 – 31/03/2020)*	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) total (to nearest £100) £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000
Chris Fearnes Non-Executive Director	5 – 10	13	-	-	-	5 – 10
Debbie Nixon Non-Executive Director	5 – 10	10	-	-	-	5 – 10
Adam Williams Non-Executive Director	5 – 10	6	-	-	-	5 – 10
Tracey Orr Non-Executive Director 01/04/2019 – 30/11/2019	0 – 5	-	-	-	-	0 – 5

Medical Directors remuneration in relation to clinical role was as follows:

- Dr Mark Weaver £150,000 - £155,000

Between 1 September 2018 and 31 October 2019, the services of Robert Pickup as Interim Director of Finance, Performance and IM&T were provided under an agreement with Birmingham and Solihull Mental Health NHS Foundation Trust. The benefit paid to Birmingham and Solihull Mental Health Partnership NHS Trust from 1 April 2019 and 31 October 2019 in respect of these services was £73,000.

Senior staff members that regularly attend the Board and are non-voting include the following:

- Paul Lewis-Grundy, Company Secretary

Pension benefits – 2020/21 (Subject to Audit)

Name Title Period of Office (if not 01/04/2020 – 31/03/2021)	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 31 March 2021 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value at 1 April 2020 £000	(f) Real increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2021 £000	(h) Employer's contribution to stakeholder pension £000
Caroline Brunt Director of Nursing and Allied Health Professionals (Interim)	2.5-5.0	2.5-5.0	35-40	105-110	777	71	876	-
Matthew Gamage Director of Finance (Interim)	5.0-7.5	12.5-15.0	30-35	70-75	385	91	497	-
Stephanie Cartwright Director of Operations, Strategy and Partnerships (Interim)	5.0-7.5	12.5-15.0	30-35	60-65	366	93	480	-
Dr Chris Weiner Interim Medical Director	2.5-5.0	5.0-7.5	30-35	65-70	483	62	570	-

Between 1 May 2020 and 31 March 2021, the services of Dr Chris Weiner as Interim Medical Director were provided under an agreement with NHS England and Improvement. The benefit paid to NHS England 1 April 2020 and 31 March 2021 in respect of these services was £147,000.

Cash Equivalent Transfer Values Disclosures for Directors (Subject to Audit)

As Non-Executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive directors.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual.

The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Treatment of Pension Liabilities in the Accounts

The policy on accounting for pensions can be found at note 9 to the Annual Accounts, and details of the pension schemes to which Dudley and Walsall Mental Health Partnership NHS Trust has contributed, together with the amount of employer contributions, are detailed in note 8 to the Annual Accounts.

Details of Directors' pension entitlements are contained in the Remuneration Report.

Compensation for loss of office (Subject to Audit)

The Trust made no compensation for loss of office during 2020/21.

Payments to past directors (Subject to Audit)

The Trust made no payments to past directors during 2020/21.

Pay Multiples (Subject to Audit)

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 the Trust in the financial year 2020/21 was £132,500 (2019/20 £202,500). This was 5.2 times (2019/20, 6.4 times) the median remuneration of the workforce, which was £25,342 (2019/20 £31,821).

The decrease in the ratio between 2019/20 and 2020/21 was due to the decrease in remuneration of the highest paid director, following the transfer of staff and services out of the Trust on 1st April 2020.

In 2020/21 no employee received remuneration in excess of the highest-paid director.

Remuneration ranged from £5,650 to £131,031.

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

Staff Report

Our workforce is typical of most NHS provider organisations with female staff making up the majority of employees, in our case 79.9% of our workforce.

Number of senior civil service staff (or senior managers) by band

Band	Headcount No.
Senior Manager	5
Consultant	1
Total	6

Staff Numbers and Costs (Subject to Audit)

Analysis of staff numbers – average number of employees on a whole time equivalent (WTE) basis.

Average Staff Numbers	2020/21			2019/20
	Permanent No.	Other No.	Total No.	Total No.
Medical and dental	2	0	**2**	89
Administration and estates	29	10	**39**	376
Healthcare assistants and other support staff	13	4	**17**	348
Nursing, midwifery and health visiting staff	24	0	**24**	490
Scientific, therapeutic and technical staff	25	1	**26**	179
Other	2	0	**2**	13
Total average numbers	**95**	**15**	**110**	**1,495**
Of which:				
No. of employees engaged on capital projects	-	-	**-**	20

The year end Whole Time Equivalent number of staff is 181 (headcount of 221). The average number of employees in the table above is lower than this, reflecting the significant growth in staffing numbers during the year.

2019/20 staff costs and numbers within this report reflect the higher number of staff which were employed when the Trust was designated as Dudley and Walsall Mental Health Partnership NHS Trust.

Staff Costs	2020/21			2019/20
	Permanent £000	Other £000	Total £000	Total £000
Salaries and wages	4,124	812	**4,936**	47,388
Social security costs	402	-	**402**	4,428
Apprenticeship levy	5	-	**5**	215
Employer's contributions to NHS pensions	763	-	**763**	8,269
Pension cost – other	-	-	**-**	16
Termination benefits	-	-	**-**	81
Temporary staff	-	1,413	**1,413**	5,628
Total gross staff costs	**5,294**	**2,225**	**7,519**	**66,025**
Of which:				
Costs capitalised as part of assets	-	-	-	2,138

Staff Composition

Staff composition by gender

Genders	Headcount No.	Headcount %
Female	177	80.1%
Male	44	19.9%
Total	**221**	**100.0**

Staff composition by grade

Grade	Female Headcount No.	Male Headcount No.	Total Headcount No.
Director	3	3	**6**
Employee	174	41	**215**
Total	**177**	**44**	**221**

Staff turnover

Staff turnover in 2020/21 was 9.14%.

Staff survey

Our staff survey was limited to the two mental health services, and as a consequence the number of respondents was very small (38).

76.36% of staff who were involved in the national staff survey would recommended DIHC as a place to work or receive treatment.

Sickness absence data

	2020/21 No.	2019/20 No.
Total Days Lost FTE	803	19,921
Avg FTE of Staff	168	1,171
Average Absence Days Lost per FTE	4.8	17.0

Staff policies

DIHC has adopted the policies of the previous Dudley & Walsall Mental Health Trust, along with policies from other organisations that have transferred in via TUPE arrangements, including, but not exclusive to Recruitment and Selection and Equality & Diversity. Policies are located on our intranet site for all staff. We have begun a process of harmonisation of policies to ensure they are aligned to our organisational commitments and objectives.

Supporting staff with disabilities

We are a disability-confident employer; we are committed to supporting staff who have a disability or become disabled during their employment. As part of this commitment, we guarantee an interview to those who meet the minimum criteria of the role and make adjustments for applicants with disabilities.

Modern Slavery Statement 2020/21

This statement, made pursuant to section 54(1) of the Modern Slavery Act 2015, sets out the approach taken by the Trust to understand all potential modern slavery risks related to its business, and the actions undertaken to mitigate any such risks during the financial year ended 31st March 2021.

The Trust is committed to delivering high standards of corporate governance and a key element of this is managing the Trust in a socially responsible way. The Trust is absolutely committed to preventing slavery and human trafficking in its corporate activities and its supply chains. The Trust also expects the same high standards which we set for ourselves from those parties with whom we engage, such as our suppliers and customers.

Due to the nature of our business and our approach to governance, we assess that there is very low risk of slavery and human trafficking in our business and supply chains. However, we aim to periodically review the effectiveness of the relevant policies and procedures that we have in place. We do not have key performance indicators in relation to slavery or human trafficking as any instance would be expected to be a breach of law, our supplier standards and/or our company policies.

Trade Union Facility Time Reporting Requirements

Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
2	2.00 WTE

Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	1
1-50%	1
51%-99%	-
100%	-

Percentage of pay bill spent on facility time

First Column	Figures
Provide the total cost of facility time	£634
Provide the total pay bill	£7,459k
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.009%

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: *(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100*	0.923%

Expenditure on Consultancy

Expenditure on consultancy in 2020/21 was £595,000 (2019/20: £338,000).

Reporting related to the review of Tax Arrangement of Public Sector Appointee

Following the Review of the Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the treasury on 23 May 2012, departments and their arm's length bodies (this is taken to include all those bodies included within the DHSC reporting boundary) must publish information on their highly paid and/or senior off-payroll engagements.

Off-payroll engagements

For all off-payroll engagements as of 31 March 2021, for more than £245 per day and that last for longer than six months. There were no such engagements in 2020/21.

Off-payroll engagements longer than 6 months

	Number of off-payroll engagements No.
No. of existing engagements as of 31 March 2021	0
Of which:	
No. that have existed for less than one year at time of reporting	0
No. that have existed between one and two years at time of reporting	0
No. that have existed between two and three years at time of reporting	0
No. that have existed between three and four years at time of reporting	0
No. that have existed between four years or more at time of reporting	0

For all new off-payroll engagements, or those that have reached six months in duration, between 1 April 2020 and 31 March 2021, for more than £245 per day and that last for longer than six months. There are no such engagements in 2020/21.

New Off-payroll engagements

	Number of off-payroll engagements No.
No. of new engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021	0
Of which:	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to the entity) and are on the departmental payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021.

Off-payroll board members/senior official engagements

	Number of off-payroll engagements
No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	0
No. of individuals that have been deemed 'board members, and/or, senior officials with significant financial responsibility', during the financial year	6

Exit Packages (Subject to Audit)

Reporting of compensation schemes – exit packages 2020/21

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agree	Total number of exit packages
<£10,000	-	-	-
£10,001 - £25,000	-	-	-
£25,001 - £50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	-	-	-
Total resource cost (£)	-	-	-

Reporting of compensation schemes – exit packages 2019/20

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	-	-	-
£10,001 - £25,000	-	-	-
£25,001 - £50,000	-	-	-
£50,001 - £100,000	1	-	1
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	1	-	1
Total resource cost (£)	81,000	-	81,000

Exit packages: other (non-compulsory) departure payments

	2020/21		2019/20	
	Number of payments agreed	Total value of agreements £000	Number of Payments agreed	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignation (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	-	-	-	-
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Independent auditor's report to the Directors of Dudley Integrated Health and Care NHS Trust

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of Dudley Integrated Health and Care NHS Trust (the 'Trust') for the year ended 31 March 2021, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows, and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Directors' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2020 to 2021 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Directors with respect to going concern are described in the 'Responsibilities of the Directors and Those Charged with Governance for the financial statements' section of this report.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion 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 such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in 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 the other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Corporate Governance Report, comprising the Directors' Report, Statement of Chief Executive's Responsibilities and the Annual Governance Statement, does not comply with the guidance issued by NHS Improvement, or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Corporate Governance Report addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained in the Statement of directors' responsibilities in respect of the accounts [set out on page 72], the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the Trust's financial reporting process.

Auditor's 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 auditor's 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 Financial Reporting Council's website at: **www.frc.org.uk/auditorsresponsibilities**. This description forms part of our auditor's report.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021).
- We enquired of management and the Audit Committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit, and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected, or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and the risk of fraud in recognition of revenue and expenditure. We determined that the principal risks were in relation to:
  - Journals; and
  - The accrual for holiday pay.

- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on journals which impacted the net deficit/ surplus of the Trust and those which were posted after year end;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of the holiday pay accrual;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. However, detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as those irregularities that result from fraud may involve collusion, deliberate concealment, forgery, or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates.
- Assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the Trust operates
  - understanding of the legal and regulatory requirements specific to the Trust including:
    - the provisions of the applicable legislation
    - NHS Improvement's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - the Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - the Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

Independent auditor's letter to the Chair of the Audit and Risk Committee for Dudley Integrated Health and Care NHS Trust

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency, and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

Our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the Trust's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, these will be reported by exception in our Audit Completion Certificate. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2021.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's responsibilities as the accountable officer of the Trust [set out on page 73], the Chief Executive, as Accountable Officer, is responsible for putting in place proper arrangements for securing economy, efficiency, and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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 undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Dudley Integrated Health and Care NHS Trust for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency, and effectiveness in its use of resources.

Use of our report

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Signature:

Mark Stocks, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor
Birmingham

Date: 28th June 2021

Independent auditor's report to the Directors of Dudley Integrated Health and Care NHS Trust

In our auditor's report issued on 28 June 2021, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2021, in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice, until we had completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2021 issued on 28 June 2021 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

Report on other legal and regulatory requirements - the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

The Chief Executive, as Accountable Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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 review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and

- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of Dudley Integrated Health and Care NHS Trust for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

M C Stocks

Mark Stocks, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham

6 September 2021

Certificate on summarisation schedules

Trust Accounts Consolidation (TAC) Summarisation Schedules for Dudley Integrated Health & Care NHS Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2020/21 have been completed and this certificate accompanies them.

Finance Director Certificate

1. I certify that the attached TAC schedules have been compiled and are in accordance with:
    - the financial records maintained by the NHS Trust
    - accounting standards and policies which comply with the Department of Health and Social Care's Group Accounting Manual and
    - the template accounting policies for NHS Trusts issued by NHS Improvement, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.
2. I certify that the TAC schedules are internally consistent and that there are novalidation errors.
3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Trust.

Matthew Gamage, Director of Finance

Date: 28th June 2021

Chief Executive Certificate

1. I acknowledge the accompanying TAC schedules, which have been prepared and certified by the Finance Director, as the TAC schedules which the Trust is required to submit to NHS Improvement.
2. I have reviewed the schedules and agree the statements made by the Director of Finance above.

Paul Assinder, Chief Executiver

Date: 28th June 2021

NHS
Dudley Integrated Health and Care
NHS Trust

Annual accounts for the year ended

31 March 2021

Statement of Comprehensive Income

	Note	2020/21	2019/20
		£000	£000
Operating income from patient care activities	3	8,153	76,353
Other operating income	4	2,735	5,633
Operating expenses	5, 7	(10,738)	(80,904)
Operating surplus/(deficit) from continuing operations		150	1,082
Finance income	10	-	137
Finance expenses	11	(109)	-
PDC dividends payable		(3)	(817)
Net finance costs		(112)	(680)
Gains / (losses) arising from transfers by absorption	25	(45,500)	-
Surplus / (deficit) for the year		(45,462)	402
Total comprehensive income / (expense) for the period		(45,462)	402
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(45,462)	402
Remove (gains) / losses on transfers by absorption		45,500	-
Adjusted financial performance surplus / (deficit)		38	1,629

On 1 April 2020 the majority of services provided by Dudley and Walsall Mental Health Partnership NHS Trust and their associated non-current assets were transferred to Black Country Partnership NHS Foundation Trust. This resulted in a technical loss on absorption of £45,500k, which has caused the deficit for the year noted above.

Excluding the impact of this technical absorption loss, the Trust has achieved an in-year surplus of £38k.

Further detail of the transfer by absorption can be found in note 25.

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	12	-	3,569
Property, plant and equipment	13	39	28,851
Total non-current assets		**39**	**32,420**
Current assets			
Inventories	14	-	-
Receivables	15	1,859	5,663
Cash and cash equivalents	16	4,097	14,574
Total current assets		**5,956**	**20,237**
Current liabilities			
Trade and other payables	17	(2,960)	(5,984)
Borrowings	19	(1,133)	-
Provisions	20	-	(1,121)
Other liabilities	18	(85)	-
Total current liabilities		**(4,178)**	**(7,105)**
Total assets less current liabilities		**1,817**	**45,552**
Non-current liabilities			
Borrowings	19	(1,700)	-
Provisions	20	(27)	-
Total non-current liabilities		**(1,727)**	**-**
Total assets employed		**90**	**45,552**
Financed by			
Public dividend capital		2,321	47,821
Revaluation reserve		-	255
Income and expenditure reserve		(2,231)	(2,524)
Total taxpayers' equity		**90**	**45,552**

The notes on pages 7 to 37 form part of these accounts.

On 1 April 2020 the majority of services provided by Dudley and Walsall Mental Health Partnership NHS Trust and their associated non-current assets were transferred to Black Country Partnership NHS Foundation Trust. The resulting transfer of cash, non-current assets and taxpayers' equity is described further in note 25.

Paul Assinder **Chief Executive Officer**

Date 28 June 2021

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**47,821**	**255**	**(2,524)**	**45,552**
Surplus/(deficit) for the year	-	-	38	**38**
Transfers by absorption	-	-	(45,500)	**(45,500)**
Transfers by absorption: transfers between reserves	(45,500)	(255)	45,755	**-**
Taxpayers' and others' equity at 31 March 2021	**2,321**	**-**	**(2,231)**	**90**

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**47,674**	**255**	**(2,926)**	**45,003**
Prior period adjustment	-	-	-	-
Taxpayers' and others' equity at 1 April 2019 - restated	**47,674**	**255**	**(2,926)**	**45,003**
Surplus/(deficit) for the year	-	-	402	402
Public dividend capital received	147	-	-	147
Taxpayers' and others' equity at 31 March 2020	**47,821**	**255**	**(2,524)**	**45,552**

Information on reserves

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 organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Financial assets reserve

This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Merger reserve

This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note	2020/21	2019/20
		£000	£000
Cash flows from operating activities			
Operating surplus / (deficit)		150	1,082
Non-cash income and expense:			
Depreciation and amortisation	5.1	13	1,903
Net impairments	6	-	1,227
(Increase) / decrease in receivables and other assets		3,795	(925)
Increase / (decrease) in payables and other liabilities		(2,387)	(1,266)
Increase / (decrease) in provisions		(1,094)	430
Net cash flows from / (used in) operating activities		**477**	**2,451**
Cash flows from investing activities			
Interest received		9	140
Purchase of intangible assets		(85)	(2,845)
Purchase of PPE and investment property		(467)	(3,422)
Net cash flows from / (used in) investing activities		**(543)**	**(6,127)**
Cash flows from financing activities			
Public dividend capital received		-	147
Movement on other loans		2,833	-
Interest on loans		(109)	-
PDC dividend (paid) / refunded		(3)	(715)
Net cash flows from / (used in) financing activities		**2,721**	**(568)**
Increase / (decrease) in cash and cash equivalents		**2,655**	**(4,244)**
Cash and cash equivalents at 1 April - brought forward		**14,574**	**18,818**
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		**14,574**	**18,818**
Cash and cash equivalents transferred under absorption accounting	25	(13,132)	-
Cash and cash equivalents at 31 March	16.1	**4,097**	**14,574**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care 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 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) 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.

On 1 April 2020 the majority of services provided by Dudley and Walsall Mental Health Partnership NHS Trust and their associated non-current assets were transferred to Black Country Partnership NHS Foundation Trust. The resulting transfer of cash, non-current assets and taxpayers' equity is described further in note 25. This transfer of services also means that amounts recorded in the prior financial year are not necessarily comparable with those recorded in the current financial year.

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.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Dudley Integrated Health and Care NHS Trust, The Dudley Group NHS Foundation Trust and Black Country Healthcare NHS Foundation Trust have been working together in the local system to further integrate healthcare services for all in Dudley. There is a real need to improve the health of our local communities and address inequalities within Dudley and we continue to work as a partnership to do this.

The local system will actively pursue the transfer of children's services and community services to Dudley Integrated Health and Care NHS Trust from Black Country Healthcare NHS Foundation Trust and The Dudley Group NHS Foundation Trust, with the aim to transfer these services on or before the 1st April 2022, subject to the appropriate assurance processes. Discussions around which services specifically will transfer will be led by primary and secondary care clinicians and a decision will be taken by the end of June 2021.

On the 1st April 2021, there was a successful transfer of the School Nursing services from Shropshire Community Health NHS Trust. Agreed funding for this service, along with continuing funding for those services which were already delivered by the Trust means that the Trust has secured adequate funding to continue for a period to at least June 2022. The Trust has not received any notice of disoultion from the Department of Health and Social Care therefore presumes that the health services provided by the Trust will continue to be provided for the foreseeable future.

Note 1.3 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).

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.

Note 1.4 Other forms of income

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 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 period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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 lives.

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 enterprise 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.

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.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

Note 1.7 Property, plant and equipment (Cont'd)

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in 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' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

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 expenditure.

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 arise from a clear consumption of economic benefits or of 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 that arises from a clear consumption of economic benefit or of 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 expenditure 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.

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

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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 useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max lif Years
Plant & machinery	-	10
Information technology	-	5
Furniture & fittings	-	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

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 where it meets the requirements set out in IAS 38.

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.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back

into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

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

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Note 1.11 Financial assets and financial liabilities (Cont'd)

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets

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).

Credit losses are determined using an expected credit loss provision matrix. Lifetime expected loss rates have been calculated with reference to historical experience of losses incurred on Local Authority and other Non-NHS contract receivables, with separate loss rates established for each. Adjustments are made for any forward looking information available to the Trust at the point that the provision is made.

Credit losses are not normally recognised in relation to other NHS organisations.

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.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.12 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

		Inflation rate
	Year 1	1.90%
	Year 2	2.00%
	Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the 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 Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 20.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The 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 NHS Resolution 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.

Note 1.13 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 organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts

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

Note 1.14 Value added tax

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

Note 1.15 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *Financial Reporting Model (FReM)*.

Note 1.16 Transfers of functions to other NHS bodies

For functions that the Trust has transferred to another NHS body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss corresponding to the net assets transferred is recognised within expenses, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Details of transfers of functions to other NHS bodies during the year are included in note 25.

Note 1.17 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.18 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared

to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the Trust does not expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Note 2 Operating Segments

Note Operating segments

The Trust operates as a single operating segment, the provision of Healthcare.

As a single segment the Trust receives £8,281,000 (2019/20: £70,379,000) of its income from CCGs. This equates to 76% (2019/20: 86%) of the Trust's total income of £10,888,000 (2019/20: £81,986,000).

The Trust receives in excess of 10% of its income from a single organisation, Dudley CCG £6,176,000. In 2019/20, the Trust received in excess of 10% of its income from two organisations, Dudley CCG £31,879,000 and Walsall CCG £31,661,000.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.

Note 3.1 Income from patient care activities (by nature)	2020/21	2019/20
	£000	£000
Mental health services		
Block contract / system envelope income*	3,437	71,363
Clinical partnerships providing mandatory services (including S75 agreements)	-	946
Other clinical income from mandatory services	194	1,395
All services		
Additional pension contribution central funding**	207	2,502
Other clinical income	4,315	147
Total income from activities	**8,153**	**76,353**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)	2020/21	2019/20
Income from patient care activities received from:	**£000**	**£000**
NHS England	218	5,137
Clinical commissioning groups	7,215	70,261
Other NHS providers	194	-
Local authorities	19	946
Non NHS: other	507	9
Total income from activities	**8,153**	**76,353**
Of which:		
Related to continuing operations	8,153	76,353
Related to discontinued operations	-	-

Note 4 Other operating income

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Education and training	66	-	**66**	2,791	96	**2,887**
Non-patient care services to other bodies	-		-	1,286		**1,286**
Provider sustainability fund (2019/20 only)			-	700		**700**
Reimbursement and top up funding	1,544		**1,544**			-
Income in respect of employee benefits accounted on a gross basis	-		-	419		**419**
Charitable and other contributions to expenditure		55	**55**		18	**18**
Other income*	1,070	-	**1,070**	323	-	**323**
Total other operating income	**2,680**	**55**	**2,735**	**5,519**	**114**	**5,633**
Of which:						
Related to continuing operations			2,735			5,633
Related to discontinued operations			-			-

* Other income includes funding received specifically for the establishment of the reconfigured organisation (£571k) and for delivery of non-clinical services transferred to the Trust from Dudley CCG (£499k).

Note 5.1 Operating expenses	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	17	347
Purchase of healthcare from non-NHS and non-DHSC bodies	165	115
Staff and executive directors costs	7,459	63,887
Remuneration of non-executive directors	111	60
Supplies and services - clinical (excluding drugs costs)	61	170
Supplies and services - general	240	799
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	198	1,772
Consultancy costs	595	338
Establishment	316	759
Premises	13	4,324
Transport (including patient travel)	14	521
Depreciation on property, plant and equipment	13	1,333
Amortisation on intangible assets	-	570
Net impairments	-	1,227
Movement in credit loss allowance: contract receivables / contract assets	75	4
Increase/(decrease) in other provisions	27	-
Audit fees payable to the external auditor		
audit services- statutory audit	64	59
other auditor remuneration (external auditor only)	-	12
Internal audit costs	51	26
Clinical negligence	46	242
Legal fees	269	135
Insurance	30	3
Education and training	56	823
Rentals under operating leases	-	246
Other services, e.g. external payroll	903	3,132
Other	15	-
Total	**10,738**	**80,904**
Of which:		
Related to continuing operations	10,738	80,904
Related to discontinued operations	-	-

Note 5.2 Other auditor remuneration	2020/21	2019/20
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit-related assurance services	-	12
Total	-	**12**

Note 5.2 Other auditor remuneration

The limitation on auditor's liability for external audit work is £2 million (2019/20: £2 million).

Note 6 Impairment of assets	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	-	1,227
Total net impairments charged to operating surplus / deficit	-	**1,227**
Impairments charged to the revaluation reserve	-	-
Total net impairments	-	**1,227**

Note 7 Employee benefits	2020/21	2019/20
	Total	Total
	£000	£000
Salaries and wages	4,936	47,388
Social security costs	402	4,428
Apprenticeship levy	5	215
Employer's contributions to NHS pensions	763	8,269
Pension cost - other	-	16
Termination benefits	-	81
Temporary staff (including agency)*	1,413	5,628
Total gross staff costs	**7,519**	**66,025**
Recoveries in respect of seconded staff	(60)	-
Total staff costs	**7,459**	**66,025**
Of which		
Costs capitalised as part of assets	-	2,138

*Included in temporary staff is £824k relating to the provision of the staffing of the Pensnett Respiratory Assessment Centre, the hub for all patients in Dudley needing to be seen by a health care professional through the COVID-19 crisis.

Note 7.1 Retirements due to ill-health

During 2020/21 there were no early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £0k (£17k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 8 Pension costs

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 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 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 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 at 20.6%, and the Scheme Regulations were amended accordingly.

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.

Note 9 Operating leases

Note 9.1 Dudley Integrated Health and Care NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Dudley Integrated Health and Care NHS Trust is the lessee.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	-	246
Total	-	**246**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
- not later than one year;	-	213
- later than one year and not later than five years;	-	455
- later than five years.	-	122
Total	-	**790**
Future minimum sublease payments to be received	-	**-**

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2020/21	2019/20
	£000	**£000**
Interest on bank accounts	-	137
Total finance income	**-**	**137**

Note 11 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2020/21	2019/20
	£000	**£000**
Interest expense:		
Other loans	109	-
Total interest expense	**109**	**-**
Total finance costs	**109**	**-**

Note 12.1 Intangible assets - 2020/21	**Software licences**	**Intangible assets under construction**	**Total**
	£000	**£000**	**£000**
Valuation / gross cost at 1 April 2020 - brought forward	**5,766**	**-**	**5,766**
Transfers by absorption	(5,766)	-	**(5,766)**
Valuation / gross cost at 31 March 2021	**-**	**-**	**-**
Amortisation at 1 April 2020 - brought forward	**2,197**	-	**2,197**
Transfers by absorption	(2,197)	-	**(2,197)**
Amortisation at 31 March 2021	**-**	**-**	**-**
Net book value at 31 March 2021	**-**	**-**	**-**
Net book value at 1 April 2020	**3,569**	**-**	**3,569**

Note 12.2 Intangible assets - 2019/20	**Software licences**	**Intangible assets under construction**	**Total**
	£000	**£000**	**£000**
Valuation / gross cost at 1 April 2019 - as previously stated	**2,948**	**612**	**3,560**
Prior period adjustments	**-**	**-**	**-**
Valuation / gross cost at 1 April 2019 - restated	**2,948**	**612**	**3,560**
Transfers by absorption	-	-	**-**
Additions	1,837	1,054	**2,891**
Reclassifications	1,666	(1,666)	**-**
Disposals / derecognition	(685)	-	**(685)**
Valuation / gross cost at 31 March 2020	**5,766**	**-**	**5,766**
Amortisation at 1 April 2019 - as previously stated	**2,312**	-	**2,312**
Prior period adjustments	**-**	-	**-**
Amortisation at 1 April 2019 - restated	**2,312**	**-**	**2,312**
Transfers by absorption	-	-	**-**
Provided during the year	570	-	**570**
Disposals / derecognition	(685)	-	**(685)**
Amortisation at 31 March 2020	**2,197**	**-**	**2,197**
Net book value at 31 March 2020	**3,569**	**-**	**3,569**
Net book value at 1 April 2019	**636**	**612**	**1,248**

Note 13.1 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**4,002**	**22,667**	**912**	**1,117**	**27**	**2,393**	**595**	**31,713**
Transfers by absorption	(4,002)	(22,667)	(912)	(1,115)	(27)	(2,329)	(585)	**(31,637)**
Valuation/gross cost at 31 March 2021	**-**	**-**	**-**	**2**	**-**	**64**	**10**	**76**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**10**	**-**	**586**	**22**	**1,867**	**377**	**2,862**
Transfers by absorption	-	(10)	-	(586)	(22)	(1,846)	(374)	**(2,838)**
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**-**	**33**	**4**	**37**
Net book value at 31 March 2021	**-**	**-**	**-**	**2**	**-**	**31**	**6**	**39**
Net book value at 1 April 2020	**4,002**	**22,657**	**912**	**531**	**5**	**526**	**218**	**28,851**

Note 13.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**3,852**	**22,939**	**-**	**1,157**	**27**	**2,427**	**632**	**31,034**
Prior period adjustments	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2019 - restated	**3,852**	**22,939**	**-**	**1,157**	**27**	**2,427**	**632**	**31,034**
Transfers by absorption	-	-	-	-	-	-	-	-
Additions	**150**	**1,799**	**912**	**110**	**-**	**196**	**69**	**3,236**
Revaluations	-	(2,071)	-	-	-	-	-	**(2,071)**
Disposals / derecognition	**-**	**-**	**-**	**(150)**	**-**	**(230)**	**(106)**	**(486)**
Valuation/gross cost at 31 March 2020	**4,002**	**22,667**	**912**	**1,117**	**27**	**2,393**	**595**	**31,713**
Accumulated depreciation at 1 April 2019 - as previously stated	**-**	**11**	**-**	**603**	**20**	**1,814**	**411**	**2,859**
Prior period adjustments	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Accumulated depreciation at 1 April 2019 - restated	**-**	**11**	**-**	**603**	**20**	**1,814**	**411**	**2,859**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**-**	**843**	**-**	**133**	**2**	**283**	**72**	**1,333**
Impairments	**-**	**1,227**	**-**	**-**	**-**	**-**	**-**	**1,227**
Revaluations	**-**	**(2,071)**	**-**	**-**	**-**	**-**	**-**	**(2,071)**
Disposals / derecognition	**-**	**-**	**-**	**(150)**	**-**	**(230)**	**(106)**	**(486)**
Accumulated depreciation at 31 March 2020	**-**	**10**	**-**	**586**	**22**	**1,867**	**377**	**2,862**
Net book value at 31 March 2020	**4,002**	**22,657**	**912**	**531**	**5**	**526**	**218**	**28,851**
Net book value at 1 April 2019	**3,852**	**22,928**	**-**	**554**	**7**	**613**	**221**	**28,175**

Note 13.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	-	-	-	2	-	31	6	**39**
NBV total at 31 March 2021	**-**	**-**	**-**	**2**	**-**	**31**	**6**	**39**

Note 13.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	4,002	22,657	912	531	5	526	218	**28,851**
NBV total at 31 March 2021	**4,002**	**22,657**	**912**	**531**	**5**	**526**	**218**	**28,851**

Note 14 Inventories

Inventories recognised in expenses for the year were £55k (2019/20: £0k). Write-down of inventories recognised as expenses for the year were £0k (2019/20: £0k).

In response to the COVID-19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £55k of items purchased by DHSC.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 15.1 Receivables	**31 March 2021**	**31 March 2020**
	£000	**£000**
Current		
Contract receivables	1,887	4,796
Allowance for impaired contract receivables / assets	(85)	(10)
Prepayments (non-PFI)	30	398
Interest receivable	-	9
VAT receivable	4	126
Other receivables	23	344
Total current receivables	**1,859**	**5,663**
Of which receivable from NHS and DHSC group bodies:		
Current	1,339	4,472
Non-current	-	-

Note 15.2 Allowances for credit losses	2020/21		2019/20	
	Contract receivables and contract assets	**All other receivables**	**Contract receivables and contract assets**	**All other receivables**
	£000	**£000**	**£000**	**£000**
Allowances as at 1 April - brought forward	**10**	**-**	**6**	**-**
New allowances arising	**75**	**-**	**4**	**-**
Allowances as at 31 Mar 2021	**85**	**-**	**10**	**-**

Note 15.3 Exposure to credit risk

The Trust's exposure to credit risk is quantified below.

Credit Loss Provision - Local Authority Contract Receivables	Gross Amount	Lifetime Expected Loss Rate	Lifetime Expected Loss Allowance
	£000	**%**	**£000**
Days past due date			
Current	0	1.19	0
1-30 Days	0	0.84	0
31-60 Days	0	0.01	0
61-90 Days	0	0.51	0
Over 90 Days	35	2.84	1
Total	**35**		**1**

Credit Loss Provision - Other Non-NHS Contract Receivables	Gross Amount	Lifetime Expected Loss Rate	Lifetime Expected Loss Allowance
	£000	**%**	**£000**
Days past due date			
Current	347	2.68	9
1-30 Days	0	3.23	0
31-60 Days	7	0.08	0
61-90 Days	0	0.15	0
Over 90 Days	47	0.79	0
Total	**401**		**9**

Credit Loss Provision - NHS Non Contract Receivables

	Gross Amount	Lifetime Expected Loss Rate	Lifetime Expected Loss Allowance
	£000	%	£000
Days past due date			
Current	176	42.5	75
Total	**176**		**75**

Note 16.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2020/21	2019/20
	£000	£000
At 1 April	**14,574**	**18,818**
Transfers by absorption	(13,132)	-
Net change in year	2,655	(4,244)
At 31 March	**4,097**	**14,574**
Broken down into:		
Cash at commercial banks and in hand	-	4
Cash with the Government Banking Service	4,097	14,570
Total cash and cash equivalents as in SoFP	**4,097**	**14,574**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**4,097**	**14,574**

Note 16.2 Third party assets held by the Trust

Dudley Integrated Health and Care NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2021	31 March 2020
	£000	£000
Bank balances	32	23
Total third party assets	**32**	**23**

Note 17.1 Trade and other payables	31 March 2021	31 March 2020
	£000	£000
Current		
Trade payables	807	1,449
Capital payables	-	552
Accruals	1,580	1,518
Social security costs	168	748
VAT payables	-	2
Other taxes payable	-	565
Other payables	405	1,150
Total current trade and other payables	**2,960**	**5,984**
Of which payables from NHS and DHSC group bodies:		
Current	1,318	515
Non-current	-	-

Note 18 Other liabilities

	31 March 2021	31 March 2020
	£000	£000
Current		
Deferred income: contract liabilities	85	-
Total other current liabilities	**85**	**-**

Note 19.1 Borrowings

	31 March 2021	31 March 2020
	£000	£000
Current		
Other loans	**1,133**	**-**
Total current borrowings	**1,133**	**-**
Non-current		
Other loans	1,700	-
Total non-current borrowings	**1,700**	**-**

Note 19.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Other loans	Total
	£000	£000
Carrying value at 1 April 2020	-	-
Cash movements:		
Financing cash flows - payments and receipts of principal	2,833	2,833
Financing cash flows - payments of interest	(109)	(109)
Non-cash movements:		
Application of effective interest rate	109	109
Carrying value at 31 March 2021	2,833	2,833

Note 19.3 Reconciliation of liabilities arising from financing activities - 2019/20

	Other loans	Total
	£000	£000
Carrying value at 1 April 2019	-	-
Carrying value at 31 March 2020	-	-

Note 20.1 Provisions for liabilities and charges analysis

	Legal claims	Other	Total
	£000	£000	£000
At 1 April 2020	31	1,090	1,121
Arising during the year	-	27	27
Utilised during the year	(31)	(789)	(820)
Reversed unused	-	(301)	(301)
At 31 March 2021	-	27	27
Expected timing of cash flows:			
- later than one year and not later than five years;	-	27	27
Total	-	27	27

Included within other provisions is £27k (2019: £0) which relates to dilapidations at Progress Point, an estate which was negotiated by the Trust during the year ended 31st March 2021 and occupied from 1st April 2021. It is expected that dilapidations will be payable at the end of the lease term.

Note 20.2 Clinical negligence liabilities

At 31 March 2021, £289k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Dudley Integrated Health and Care NHS Trust (31 March 2020: £341k).

Note 21 Contractual capital commitments

	31 March 2021	31 March 2020
	£000	£000
Property, plant and equipment	-	378
Intangible assets	-	13
Total	**-**	**391**

Note 22 Financial instruments

Note 22.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners, and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

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

Interest rate risk

The Trust may borrow from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust has borrowed from Black Country Healthcare NHS Foundation Trust non-recurrently to fund the initial investment required in the establishment of the Trust. Interest is payable at a rate of 3.50% and therefore does not expose the Trust to significant interest rate risk.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2021 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with clinical commissioning groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 22.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Total book value
	£000	**£000**
Trade and other receivables excluding non financial assets	1,825	**1,825**
Cash and cash equivalents	4,097	**4,097**
Total at 31 March 2021	**5,922**	**5,922**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	5,139	**5,139**
Cash and cash equivalents	14,574	**14,574**
Total at 31 March 2020	**19,713**	**19,713**

Note 22.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	**£000**
Other borrowings	2,833	**2,833**
Trade and other payables excluding non financial liabilities	2,792	**2,792**
Provisions under contract	27	**27**
Total at 31 March 2021	**5,652**	**5,652**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Total book value
	£000	**£000**
Trade and other payables excluding non financial liabilities	4,669	**4,669**
Provisions under contract	1,121	**1,121**
Total at 31 March 2020	**5,790**	**5,790**

Note 22.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021	31 March 2020
	£000	**£000**
In one year or less	3,926	5,790
In more than one year but not more than five years	1,726	-
Total	**5,652**	**5,790**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 22.5 Fair values of financial assets and liabilities

It is considered that the book value (carrying value) of financial assets and liabilities is a reasonable approximation of fair value.

Note 23 Losses and special payment

	2020/21		2019/20	
	Total number of cases	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Fruitless payments and constructive losses	-	-	10	4
Total losses	**-**	**-**	**10**	**4**
Special payments				
Ex-gratia payments	-	-	6	1
Total special payments	**-**	**-**	**6**	**1**
Total losses and special payments	**-**	**-**	**16**	**5**
Compensation payments received		-		-

Note 24 Related parties

In relation to related parties, the Trust has considered materiality from the perspective of the Trust and that of the Trust's counter parties and set materiality at an appropriate level.

During the year there have been some transactions with parties related to the Trust's Board of Directors, as below:

	Income 2020/21	Expenditure 2020/21	Receivables 31 March 2021	Payables 31 March 2021
	£000	**£000**	**£000**	**£000**
Future Proof Health Limited	-	824	-	58
Halesowen Medical Practice	14	8	14	-
Keelinge House Surgery	-	1	-	-
Three Villages Medical Practice	-	1	-	-

In March 2020, Dudley CCG made the decision to commission clinical staffing services from Future Proof Health Ltd for the Dudley COVID-19 'Red Centre' (subsequently the Pensnett Respiratory Assessment Centre) under the Emergency Preparedness, Resilience and Response (EPRR) arrangements.

Subsequently, the CCG determined that a contract for the operational management of this centre should be awarded to DIHC. At the DIHC Board meeting in April 2020, the Trust approved lead provider responsibilities for these services, including operational responsibility for the Centre's staff. For operational continuity purposes this resulted in a subcontract being agreed by DIHC with Future Proof Health Ltd. Importantly, this Board decision was taken prior to those Associate Non Executives (local GPs) who have declared an interest in Future Proof Health Ltd, being appointed to the DIHC Board or having any influence on this decision.

The Department of Health and Social Care is regarded as a related party. During the year Dudley Integrated Health and Care NHS Trust has had a number of material transactions with entities for which the Department of Health and Social Care is regarded as the parent Department. These included:

	Income 2020/21	Expenditure 2020/21	Receivables 31 March 2021	Payables 31 March 2021
	£000	£000	£000	£000
Black Country Healthcare NHS Foundation Trust	194	933	944	414
Salford Royal NHS Foundation Trust	-	125	-	68
South Warwickshire NHS Foundation Trust	-	51	-	-
The Dudley Group NHS Foundation Trust	-	-	-	43
Walsall Healthcare NHS Trust	-	75	-	75
NHS Barking and Dagenham CCG	-	-	3	-
NHS Bradford District and Craven CCG	-	-	1	-
NHS Dudley CCG	6,176	583	-	410
NHS Liverpool CCG	-	-	6	-
NHS Manchester CCG	-	-	1	-
NHS Oxfordshire CCG	-	-	2	-
NHS Sandwell and West Birmingham CCG	2,107	54	-	25
NHS South East Staffs and Seisdon Peninsula CCG	1	-	-	-
NHS South West London CCG	-	-	1	-
NHS Walsall CCG	-	-	110	-
NHS Wolverhampton CCG	-	-	2	-
NHS England	1,555	174	269	232
Health Education England	66	-	-	-
NHS Resolution	-	75	-	-
Care Quality Commission	-	52	-	52

In addition, the Trust has had a number of material transactions with other Government Departments and Other Central and Local Government Bodies. These included:

	Income 2020/21	Expenditure 2020/21	Receivables 31 March 2021	Payables 31 March 2021
	£000	£000	£000	£000
HM Revenue & Customs - VAT	-	-	4	-
HM Revenue & Customs - Other taxes and duties and NI contributions (Expenditure includes apprenticeship levy and employer NI contributions. Balances include both employer and employee contributions / PAYE deductions).	-	407	-	168
NHS Pension Scheme	-	763	-	321
Welsh Health Bodies - Hywel Dda Health Board	-	-	1	-
Scottish Government	-	-	5	-
National Employment Savings Trust (NEST)	-	-	17	-
Dudley Metropolitan Borough Council	19	-	9	-
Walsall Metropolitan Borough Council	-	-	49	-

Note 25 Transfers by absorption

On 1 April 2020 the majority of services provided by Dudley and Walsall Mental Health Partnership NHS Trust and their associated non-current assets were transferred to Black Country Partnership NHS Foundation Trust. The newly merged organisation is operating as Black Country Healthcare NHS Foundation Trust. Two services, Dudley Improving Access to Psychological Therapies (IAPT) and Dudley Primary Mental Health Team, remained within the Trust along with their associated non-current assets and all net current assets.

The resulting transfer by absorption is detailed below:

	Closing SoFP as at 31st March 2020	Transfer out of the Trust on 1st April 2020	Opening SoFP as at 1st April 2020
	£000	**£000**	**£000**
Non-current assets			
Intangible assets	3,569	(3,569)	-
Property, plant and equipment	28,851	(28,799)	52
Total non-current assets	**32,420**	**(32,368)**	**52**
Current assets			
Receivables	5,663		5,663
Cash and cash equivalents	14,574	(13,132)	1,442
Total current assets	**20,237**	**(13,132)**	**7,105**
Current liabilities			
Trade and other payables	(5,984)	-	(5,984)
Provisions	(1,121)	-	(1,121)
Total current liabilities	**(7,105)**	**-**	**(7,105)**
Total assets less current liabilities	**45,552**	**(13,132)**	**-**
Total assets employed	**45,552**	**(45,500)**	**52**
Financed by			
Public dividend capital	47,821	(45,500)	2,321
Revaluation reserve	255	(255)	-
Income and expenditure reserve	(2,524)	255	(2,269)
Total taxpayers' equity	**45,552**	**(45,500)**	**52**

Note 26 Better Payment Practice code

	2020/21	2020/21	2019/20	2019/20
	Number	£000	Number	£000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	3,218	6,434	15,834	33,956
Total non-NHS trade invoices paid within target	2,677	6,054	14,370	32,069
Percentage of non-NHS trade invoices paid within target	83.2%	94.1%	90.8%	94.4%
NHS Payables				
Total NHS trade invoices paid in the year	187	14,402	838	8,101
Total NHS trade invoices paid within target	171	14,298	743	7,079
Percentage of NHS trade invoices paid within target	91.4%	99.3%	88.7%	87.4%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 27 External financing limit

The Trust is given an external financing limit against which it is permitted to underspend.

	2020/21	2020/20
	£000	£000
Cash flow financing	178	4,391
Other capital receipts	-	-
External financing requirement	**178**	**4,391**
External financing limit (EFL)	178	4,391
Under / (over) spend against EFL	**-**	**-**

Note 28 Capital Resource Limit

	2020/21	2020/20
	£000	£000
Gross capital expenditure	-	6,127
Charge against Capital Resource Limit	**-**	**6,127**
Capital Resource Limit	-	6,489
Under / (over) spend against CRL	**-**	**362**

Note 29 Breakeven duty financial performance

	2020/21
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	38
Breakeven duty financial performance surplus / (deficit)	**38**

Note 30 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		376	883	1,163	3,575	1,936	888
Breakeven duty cumulative position	202	578	1,461	2,624	6,199	8,135	9,023
Operating income		66,578	67,918	67,298	71,302	65,388	64,750
Cumulative breakeven position as a percentage of operating income		0.9%	2.2%	3.9%	8.7%	12.4%	13.9%

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	1,960	2,199	3,384	3,050	1,629	38
Breakeven duty cumulative position	10,983	13,182	16,566	19,616	21,245	21,283
Operating income	64,546	66,293	69,482	74,340	81,986	10,888
Cumulative breakeven position as a percentage of operating income	17.0%	19.9%	23.8%	26.4%	25.9%	195.5%

The breakeven cumulative net surplus of the Trust has exceeded 0.5% of operating income of the reporting year in every year of the breakeven period. The main reason for this is consistent delivery of in-year control totals as currently set by NHS Improvement. In 2020/21, the cumulative breakeven position as a percentage of operating income has increased significantly, which is as a result in the significant reduction in operating income following the transfer of services to Black Country Healthcare NHS Foundation Trust on 1st April 2020.

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