NHS
The Royal Wolverhampton
NHS Trust

Annual Report 2020/21

Safe & Effective | Kind & Caring | Exceeding Expectation

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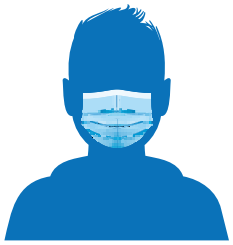


It has been a year like no other for The Royal Wolverhampton NHS Trust. Our Trust, like the rest of the NHS, were hit by COVID-19. From the start we became a hot spot for rising COVID-19 numbers and made very difficult decisions such as suspending visiting, postponing non-urgent activity and redeploying staff so we could look after the increased number of patients who needed our care. Sadly, we have lost many patients to this awful virus, as well as some of our own staff, however without the dedicated care of our workforce we would have lost many more.

There have been so many examples of our staff going above and beyond their job roles and this has been recognised locally as well as nationally. To support our staff, we have introduced a whole host of materials to help support their health and wellbeing. Some of the support included a pop-up shop dedicated for staff who were unable to go to the supermarket before or after their shift, and dedicated support rooms staff could go for a rest and refreshments. We are continuing to add to this resource as this will be a major focus this coming year.

COVID-19 has changed the way we are all working forever. We have managed to tackle the pandemic head on due to the support of the local health system. I would like to say thank you for the support given from our colleagues in neighbouring trusts, Local Authorities, Clinical Commissioning Groups as well as nationally; we were able to work as a team and support each other.

We have also been very lucky to have a strong leadership team, which has been invaluable to guiding us through this pandemic. Our Chief Executive and Executive Directors have worked tirelessly to provide staff with the support and tools that they need to get through this challenging period.

2020/21 has seen some additions to our board including Tracy Palmer as Director of Midwifery, and Sally Evans as Director of Communications and Stakeholder Engagement. We have also welcomed two new non-executive directors - Professor Anand Pandyan and John Dunn. All bringing with them a wealth of experience in their specialist fields. Welcome all.

We have built two new respiratory wards this year, scaling a combined total of 1,744 square metres. During the height of the COVID-19 pandemic, C14 was identified as a 'green' or COVID-19 negative ward for respiratory / medical patients and C26 as the 'red' (COVID-19 positive) ward. On both wards, bed space areas are greater to accommodate enhanced infection prevention for all practices. This year we were also awarded more than £1 million to help prepare for winter and improve facilities for patients. We used the input to further strengthen our A&E department.

It has been another successful year for our staff in regards to national awards. Jo Weekes, our radiographer, has become the first from the Trust in her role to receive European recognition. In January Dr Paul Harrison, Clinical Director for Black Country Pathology Services (BCPS), was awarded an MBE in the Queen's New Year Honours List for services to pathology. The award recognises Dr Harrison's commitment to pathology services within the Black Country and nationally.

Our Trust has also featured in the top ten hospital trusts in the UK for the highest number of participants involved in COVID-19 studies researching the virus. The organisation has recruited a total of 793 patients to participate across a series of nine research studies, from a total of 9,742 patients involved in 20 such studies across the West Midlands. In July we were given the top award for our commitment to supporting the Armed Forces, by being awarded an Employer Recognition Scheme Gold Award.

Everything I have highlighted here would not have been possible without the unfaltering efforts of our staff across the Trust and we are continually taken aback by what they do on a daily basis.

I would like to take this opportunity to say thank you again to them for their hard-work and dedication.

Take care,

Steve.

Professor Steve Field Chairman

A - Performance report

A1 - Performance overview

Statement from the Chief Executive - his perspective on performance over the period

This year has been one nobody will forget. I will never forget March 7th 2020 when I received a call saying we had our first COVID-19 positive patient in the Trust - it is a day that will stay with me forever. Even then I could not imagine the challenges that would face us.

It has been relentless, with limited respite, intense pressures and many unknowns. Hundreds of our staff have been redeployed to different roles to urgently support other departments and staff. Throughout it all, I have been overwhelmed by the dedication, professionalism and kindness of our staff. They continue to perform their best in the most challenging circumstances - and that is what makes RWT great.

I was very glad to see us score higher scores than other trusts in nine out of 10 core themes in this year's staff survey - reflecting the overall satisfaction of our workforce along with a year-on-year increase in staff satisfaction levels. Overall, when compared to last year's results, the core themes of 'Health and Wellbeing', along with 'Morale' both demonstrated significant improvements for RWT, as well as a higher than average score. This bodes well for the Trust, as we are working closely with staff to support them in relation to the ongoing intensity of the COVID-19 pandemic, and beyond.

I am proud to lead RWT and it's the commitment, perseverance, enthusiasm and compassion our staff display – day in, day out – that sets us apart from others and makes us a great place to work.

There have been some brilliant examples of our staff dedication this year including the set-up of an in-house production line making protective visors for staff, which made 250,000 and the organisation of a pop-up shop for staff.

I have also been overwhelmed by the support of the local community throughout this year. Our Trust, like many others, has been humbled by the huge amounts of donations of food and other items received for our staff. There has also been so much fundraising for us, something we will be forever be grateful for. A special thank you to Sir Captain Tom Moore for his fundraising efforts during the first lockdown. Captain Tom was an incredible inspiration to us here at the Trust and we would like to pay tribute to his amazing spirit and outlook, and to thank him for his incredible contribution to the NHS.

This year, more than ever, we have all pulled together with our usual skill, compassion and spirit and, alongside our partners in primary care, local authorities, social care, public health and nursing homes, we have gone above and beyond the call of duty to deal with the increasing demands on our services.

Finally, I would like to say thank you to each and every one of our staff for the passion and commitment they continue to show for our patients. They are a credit to our Trust and the wider NHS.

Prof. David Loughton, CBE

Chief Executive

Statement of the purpose and activities of the organisation: What we do

The Royal Wolverhampton NHS Trust is a statutory body which came into existence on 1st April 1994 under The NHS Trust (Establishment) Order 1993 (No 2574).

The trust is one of the largest providers of healthcare in the West Midlands, covering acute, community and primary care services. The Trusts services cover the population of Wolverhampton, the wider Black Country, South Staffordshire, North Worcestershire and Shropshire. The Trust acts as a specialist centre for a number of different services including, but not limited to, cancer, stroke and heart and lung services. In addition to this, the Trust acts as a host for the Black Country Pathology Service (BCPS) – a single pathology service run by The Dudley Group NHS Foundation Trust, Sandwell & West Birmingham Hospitals NHS Trust, Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust.

The Trust embarked on its vertical integration programme on 1 April 2016, with nine GP practices (as at April 2021) becoming part of the Trust. Being directly responsible for the delivery of primary care for this population offers the Trust a unique opportunity to redesign services across the full patient pathway.

We are the largest teaching hospital in the Black Country providing teaching and training to more than 130 medical students on rotation from the University of Birmingham Medical School. We also provide training for nurses, midwives and allied health professionals through well-established links with the University of Wolverhampton. During 2014 the Trust was established as the Host for the Clinical Research Network: West Midlands.

The Trust is the largest employer in Wolverhampton with more than 10,000 staff. Services are provided from the following locations:

- New Cross Hospital - Secondary and tertiary services, Maternity, Accident & Emergency, Critical Care and Outpatients.
- West Park Hospital - Rehabilitation, Inpatient and Day Care services, Therapy services, and Outpatients.
- Community Services - More than 20 community sites providing services for children and adults, Walk-in Centres, and Therapy and Rehabilitation services.
- Cannock Chase Hospital - General Surgery, Orthopaedics, Breast Surgery, Urology, Dermatology, and Medical Day Case investigations and treatment (including Endoscopy).
- Primary Care - nine GP practices have now joined us across Wolverhampton and Staffordshire.
- BCPS - The centre carries out tests such as; fertility tests, blood / urine analysis, tests for infection and detecting cancer.

Our local population – some public health indicators

The Trusts' main site, New Cross Hospital, resides in the heart of a diverse city with a CCG registered population of 262,000 people. Recognising the close proximity to neighbouring areas, the wider population that we serve is closer to 450,000. This covers patients from across the three Staffordshire CCGs (South East Staffordshire and Seisdon Peninsula, Cannock Chase and Stafford & Surrounds), Walsall, and, to a lesser extent, patients from other areas of the Black Country and Shropshire.

The Office of National Statistics (ONS) estimates that the population of Wolverhampton will grow by approximately 4% by 2025 with a current age profile broadly in line with that of the country as a whole. A key challenge for the Trust is the diversity of the communities we serve. Wolverhampton is characterized by high levels of deprivation whereas South Staffordshire is typically more prosperous and less ethnically diverse.

As a Trust, we work closely with colleagues in Commissioning and the Local Authority to develop the Health and Wellbeing Strategy. We also contribute to the Joint Strategic Needs Assessment (JSNA) that defines the health considerations across our communities. We know that high levels of deprivation are a determining factor in the health of a population. Life expectancy in Wolverhampton is lower than for England as a whole and the mortality rate across all causes is higher than for England as a whole. In terms of behavioural risk factors, Wolverhampton has a lower percentage of physically active adults than the country and a higher percentage classified as overweight or obese. Smoking prevalence is however slightly below the English average. Finally, males experience a health inequality at birth of 7.8 years and females, 6.3. Both are higher than the national average.

Our local population

Table 1

	Wolverhampton	South Staffordshire
Population	[1]c263k	[3]c112k
Ethnic Background	[2]White: 64.5% BME: 35.5%	[3]White: 96.5% BME: 3.5%
Life Expectancy	[1]Males: 77.3 Females: 81.9 Below national average	[3]Males: 80.3 Females: 84.3 Above national average
Quality of Life (Disability free life expectancy)	[1]Males: 58 years (lower than national average) Females: 61 years (lower than national average)	[5]Males: 71 years (higher than national average) Females: 73 years (higher than national average)
Deprivation	[1]17th most deprived LA 51.3% of population amongst the 20% most deprived nationally	[5]250th most deprived district 9% of population amongst the 20% most deprived nationally
Morbidity	[1]67.3% of adults (18+) classified as over weight or obese [2]27.7% suffer from one or more LTCs Single greatest cause of years of life lost: Cariovascular Disease	[3]62.7% of adults (18+) classified as over weight or obese [4]18.7% suffer from one or more LTCs Single greatest cause of years of life lost: Cariovascular Disease

Taken form:

[1] Health Profile 2017-19, Public Health England

[2] Wolverhampton JSNA 2019

[3] Health Profile 2017-19, Public Health England

[4] Health & Wellbeing Profile 2015 for South Staffordshire

[5] South Staffordshire E-JSNA

Activity overview 2020-2021

Table 2
Performance against the National Operational Standards

		Performance	
Indicator	**Target (2020/21)**	**2020/21**	**2019/20**
Cancer two week wait from referral to first seen date	93%	86.71%	82.11%
Cancer two week wait for breast symptomatic patients	93%	51.14%	35.19%
Cancer 31 day wait for first treatment	96%	85.66%	87.14%
Cancer 31 day wait for second or subsequent treatment - Surgery	94%	75.15%	84.84%
Cancer 31 day wait for second or subsequent treatment - Anti cancer drug	98%	97.58%	99.66%
Cancer 31 day wait for second or subsequent treatment - Radiotherapy	94%	92.51%	90.87%
Cancer 62 day wait for first treatment	85%	55.30%	58.07%
Cancer 62 day wait for treatment from Consultant screening service	90%	58.57%	60.18%
Cancer 62 day wait- Consultant upgrade (local target)	88%	68.68%	74.49%
Emergency Department - total time in ED	95%	85.56%	85.91%
Referral to treatment - incomplete pathways	92%	65.26%	84.31%
Cancelled operations on the day of surgery as a % of electives	<0.8%	0.34%	0.65%
Mixed sex accommodation breaches	0	0	0
Diagnostic tests longer than 6 weeks	<1%	45.27%	3.16%

Table 3
Performance against other National and Local Quality Requirements

		Performance	
Indicator	**Target (2020/21)**	**2020/21**	**2019/20**
Clostridium Difficile	40	46	31
MRSA	0	2	2
VTE Risk Assessment	95%	93.57%	94.48%
Duty of Candour*	0	1	0
Stroke - 90% of time spent on an acute stroke ward	80%	91.88%	94.08%
TIA - assessed and treated within 24 hours	60%	54.58%	85.02%
Ambulance handover breaches - 30-60 minutes	0	1,526	1,547
Ambulance handover breaches - 60 minutes or more	0	1,119	221
Trolley waits in A&E - no more than 12 hours	0	169	38
Referral to treatment - no one waiting longer than 52 weeks	0	2,409	0

*The Duty of Candour disclosure is subject to the appropriate investigation and reporting.

Our vision and values

The Trust has a strategy covering the period 2018-21 and whilst this will be refreshed for 2021 onwards; our vision and values are not bound by time.

Our vision – "to be an NHS organisation that continually strives to improve the outcomes and experiences for the communities we serve" reflects our relentless pursuit of continuous improvement. Our values are the beliefs that we hold that guide our behaviour in achieving this vision.

Our values:

- Safe and Effective – We will work collaboratively to prioritise the safety of all within our care environment
- Kind and Caring – We will act in the best interest of others at all times
- Exceeding Expectation – We will grow a reputation for excellence as our norm.

Our strategic objectives and the risks to achieving them

To support the achievement of our vision, we have developed a set of strategic objectives – practical goals we aim to achieve that will support us in the realisation of our vision.

Trust strategic objectives 2018-2021:

1. To have an effective and well-integrated health and care system that operates efficiently
2. Pro-actively seek opportunities to develop our services
3. Create a culture of compassion, safety and quality
4. Attract, retain and develop our staff and improve employee engagement
5. To be in the top 25% of key performance indicators
6. Maintain financial health – appropriate investment to patient services

Our risk and assurance framework is more fully described in the Annual Governance statement.

The Trust Board has identified a number of key risks to the achievement of its strategic objectives in 2020/21:

- Workforce - Recruitment and retention of staff across the Trust and in particular the future pipeline of nursing and medical staff.
- That there is a failure to deliver recurrent Cost Improvement Programmes (CIP's).
- That the deficit plan (before Sustainability and Transformation Funds) for 2018-2019 is not achieved and the medium-term financial plan fails to bring the Trust back to surplus.
- The high Summary Hospital Level - Mortality Indicator could reduce the confidence in the quality of care the Trust provides.
- That the Trust cancer performance metrics place RWT in the bottom quartile nationally.

Going concern

It is clear that the Trust should account on a going concern basis as there is no case for the Trust ceasing the provision of services, evidenced by published documents with regard to the 2020/21 Financial and Performance Plan, as well as other strategic documentation. As an existing trading entity, the Trust is not likely to be wound up and as such, it can be concluded that the Trust is a going concern. This is reaffirmed by the Trust's Statement of Financial Position as at 31 March 2021.

Key risks and issues – related to activity

Evident from the table on page nine is the impact that the pandemic has had on our ability to undertake our normal planned care programme. During the first and third waves of the virus, the Trust was forced to suspend large elements of our planned programme in order to care for patients admitted with COVID-19. This has led to a backlog of patients, like across the rest of the country, awaiting treatment. With finite physical and workforce capacity, the key risk going into 2021 is our ability to recover this backlog and minimise the indirect harm that the virus has on patients.

What we achieved – Performance summary 2020-2021

We recognise that maintaining excellent clinical care is a major indication of the support and commitment of all our colleagues from our doctors and nurses to support staff. Taken together, it is the combined effort of every member of staff, whatever their role, which enables the Trust to provide high quality and effective services.

The circumstances to achieving this have never been more challenging with the emergence of the COVID-19 disease. The year of 2020/21 has been truly unprecedented and has significantly affected the running of the hospital's normal operation (as reflected in the performance analysis later on in the report).

Some of key achievements over the past 12 months are:

The Royal Wolverhampton NHS Trust has been rated 'Good' by the Care Quality Commission (CQC) for the second time in a row. The CQC published their report in February 2020 having previously visited the Trust in August and September 2019. As well as receiving 'Good' overall, the Trust achieved an 'Outstanding' rating for the 'Caring' domain and there were a number of examples of outstanding practice in urgent and emergency care, critical care, services for children and young people and community services for adults. The CQC has also rated Cannock Chase Hospital as 'Good' across all ratings, an improvement since their last inspection. Inspectors said that they consistently heard of a highly regarded and inspirational chief executive supported by a capable, dynamic and forward-thinking board, ensuring balance of focus on quality and safety whilst striving to innovate.

At all levels of the Trust there was a positive culture that supported and valued staff, and focused on delivering the best care and experiences for patients every day. The report emphasises just how 'dedicated, kind, caring and patient focused' staff were and how 'proud staff' demonstrated an organisation that continually strives to improve the outcomes and experiences for the communities served. Eight of the 10 GP practices that have been inspected since joining RWT have also been rated as Good. The remaining two have yet to be inspected by the CQC.

The Trust's vertical integration programme continues to evolve with the Trust now having its own 'Primary Care Network' the group of vertically integrated practices working more closely together to improve patient outcomes and reduce duplication. As of April 2021, nine GP Practices are now part of the Trust. This means that we are directly responsible for the delivery of primary care. This vertical integration offers a unique opportunity to redesign services from initial patient contact, through ongoing management to end of life care. As a single organisation, the issues of scope of responsibility, funding, differing objectives and drivers will be removed, and clinicians will be in a position to design effective, high quality clinical pathways which will improve appropriate access and positively impact on patient outcomes.

We have developed a huddle tool to improve the flow of patients throughout our hospital. Trusts across the country are facing the challenge of having to maximise the through put of patients within the hospital. In order to do this visibility is needed on what patients are waiting for on a day by day basis. The Trust has invested in a Continuous Improvement Team who have developed the 'huddle' tool. A live and interactive tool showing what patients are awaiting next in their stay. Developed internally, the tool is the only one of its kind in England and allows for greater transparency on the reasons for delay.

The Trust continues to bolster its reputation for innovation and, with Babylon, have launched a 10-year partnership to develop a new healthcare delivery model of 'Digital-First Integrated Care', for 300,000 people across Wolverhampton and its surrounding areas. Patients will get greater control over their own health, faster treatment, fewer trips to hospital, treatment from their own home and greater access to their own data. Staff will have time freed-up for patients with the most urgent and complex issues, avoid duplication, and improve information-sharing.

All of the above were achieved in the midst of a global pandemic, making the achievements even more remarkable. A success in itself is the way in which the Trust has responded to the pandemic. During the heights of the pandemic, over 800 staff were redeployed across the Trust. Whilst most were redeployed to offer direct clinical care, others were released to supporting roles. The Trust developed its own PPE factory with 250,000 visors hand made by staff. A staff pop up shop was created to support staff who could not get to a supermarket – 21,000 items being sold in the process. Two new wards were also built in a matter of weeks. In fighting the disease, we have developed our own vaccination hub and just under 7,000 staff have been vaccinated at the time of writing.

A2 – Performance analysis

Performance analysis

A summary of our performance against the key national standards is shown in the previous section. The impact of the COVID-19 pandemic is seen across all of the standards. During the first and third waves of the virus, the Trust was forced to suspend large elements of our planned programme which led to an increase in both the number of patients waiting and also their respective waiting time. Following these waves, the Trust worked to restore services as quickly as possible but the impact of staff sickness, shielding, the inherent productivity constraints of working in a COVID environment and the sheer scale of the challenge, has constrained our ability to recover further. During all of this time, the Trust has focused on prioritising those patients most at need of treatment which includes those patients on a cancer pathway.

In 2021/22, the Trust will continue to follow the recovery and restoration priorities determined by NHS England/Improvement. These priorities from a performance perspective are focused on maximising activity undertaken in order of clinical priority. We expect COVID-19 to have a continued bearing on our performance.

Equality of service delivery

Given the diversity of the population that we serve, the Trust is very mindful of the health inequalities that exist. That is why we are committed to ensuring that we treat all of our patients equally and based solely on clinical priority. We are working with partners across the system to understand the complexities behind these health inequalities, why they exist and how they can be removed.

Key financial performance information

The following summary of financial performance during 2020/21 is drawn from the annual accounts.

The Department of Health and Social Care assesses the Trust's financial performance against the following four targets, all of which have been achieved:

Income and expenditure:

As a minimum, the Trust is required to break even each year. In 2020-2021 the Trust made a surplus of £243,000 after impairment and allowing for accounting adjustments.

Capital cost absorption rate:

Within its overall expenditure, the Trust is required to pay the Department of Health and Social Care a sum equivalent to 3.5% of average net relevant assets. This payment is known as the Public Dividend Capital payment. We paid a sum equivalent to 3.5%.

External financing limit:

This refers to the agreed amount of cash that the Trust is allowed by the Department of Health and Social Care to consume over and above the amount it generates through its normal activities in year. This may be through a reduction in its own cash balances or receiving cash from external sources. The Trust is expected to not exceed its External Finance Limit (EFL) and in 2020-2021 it achieved this, spending (£12,982,000) (£15,420,000 in 2019-2020) against a limit of (£7,370,000) (limit of £18,046,000 in 2019-2020).

Capital resource limit:

This is a limit, imposed by the Department of Health and Social Care, on the level of capital expenditure which the Trust can incur in the year. The Trust should maintain its' spending at or below this level. We spent £49,900,000 (£29,431,000 in 2019-2020) against a limit of £50,701,000 (£29,431,000 in 2019-20). For 2020/2021 there is an underspend against CRL of £801,000 which was expected from NHSI/E. This underspend is PDC paid to the Trust (in June 20) in respect of costs the Trust incurred in 2019/2020 and self-funded. The PDC paid over in 2020/2021 was a 'cash top-up' and the Trust has prudently used the PDC to reimburse its cash balances.

Valuation of Trust's land and buildings:

The value of the Trust's land and buildings has been assessed by an independent professional valuer. It is based on an alternative site Modern Equivalent Asset (MEA) valuation, undertaken specifically in accordance with the HM Treasury guidance which states that such valuations are an option if the Trust's service requirements can be met from the alternative site. The value of the Trust's land and buildings at 31 March 2021 has been subject to revaluation using indices provided by the professional valuer.

New additions and refurbishments completed in year were valued by the same independent valuer on a modern equivalent asset basis.

Other key financial information includes the following:

- 117,367 invoices received during the year, 90,945 (77.5%) were paid within 30 days of receipt of goods or a valid invoice (whichever is the latter).
- Against a turnover of £743,285,000, the break-even in-year position was £243,000, with a break-even cumulative position of £60,121,000.
- The accounts for the Trust were produced in line with the Department of Health and Social Care's Group Accounting Manual, with particular judgement being exercised this year in regard to provisions, leases and useful economic lives of assets.

Sustainability

The UK has a legal obligation under the Climate Change Act of 2008 to reduce carbon emissions by 80% by 2050. This will positively affect the health of patients, the population and the health system including the NHS, with increased air quality and lower levels of high carbon travel, whilst also working to mitigate the effect of climate change.

The Department of Health and Social Care acknowledges that the health and care system in England is responsible for an estimated 4-5% of the country's carbon footprint and has a major role to play in achieving the UK carbon reduction target. The NHS has therefore committed to being the world's first 'net zero' National Health Service by setting two targets:

For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;

For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

The Trust has made significant progress in this area over the last 12 months. We now have in place a "Green Plan" as per the requirements of NHSEI and in line with meeting the Greener NHS Net Zero Plan. The key target areas focus on Carbon Emissions; Air Pollution and Single-use Plastics and we have tailored our plan to meet the required NHSEI Commitments accordingly.

The Head of Estates Development has continued to grow the membership, targets and workstreams of the Trust Sustainability Group and plans are in place to recruit a Head of Sustainability to help to drive forward the requirements of the Greener NHS Programme. Clinical representation to the Sustainability Group has been invaluable. In the coming years this area will grow across the Trust as we look to shape our services with sustainability and carbon reduction playing a central part to our thinking.

The Trust Green Plan was developed to reiterate our commitment to sustainability and to build upon previous work undertaken to reduce the environmental impact of our operational activities whilst supporting the NHS aim to sustainable healthcare delivery and becoming a Net Zero Carbon organisation. As a public funded organisation, we have an obligation to operate in a way that impacts the communities we serve in a positive manner. The Trust is committed to ensuring effective and efficient use of resources to support building healthy and resilient communities.

The Trust is currently recalculating its carbon footprint in line with new NHS requirements and we are set to continue to work alongside the Carbon Trust, the Carbon Energy Fund and other specialist service providers. The Trust is also helping to shape regional strategy within the Black Country and play a key role in supporting the STP Sustainability Network.

The NHS is well placed to set an example on carbon reduction and the adoption of sustainable best practices. Improved carbon efficiency will not only lead to financial savings but will produce far reaching environmental benefits on a global scale. The Trust is committed to the ideals of protecting and improving the environment and reducing carbon to improve our community's health.

The Trust will further develop its approach to embedding sustainable practices and where possible act as an exemplar to its community, other NHS Trusts, and partners.

Energy use:

Please find below a table outlining the amount of energy recorded used across the Trust Estate (2019/20).

Table 4

Energy	Unit	Community	New Cross	West Park	Cannock	Carbon Conversion
Electricity consumed	kWh	306,389	12,340,788	549,989	3,715,199	0.449
Gas consumed	kWh	528,285	54,767,773	2,543,365	7,228,110	0.184
Oil consumed	kWh	0	346,384	12,960	42,120	0.268
Total	**kWh**	**834,674**	**67,454,945**	**3,106,314**	**10,985,429**	

The annual imported energy consumption has dropped overall since the previous year by around 790,000 kWh. We also need to recognise that as we continue to develop the Trust estate we increase the use of energy in the provision of additional services – most notably our electricity demands. This is one of the reasons why the Trust is looking to alternative sources of green power, for example, the proposed Solar Farm development to which we are seeking associated external capital funding.

Carbon tonnage:

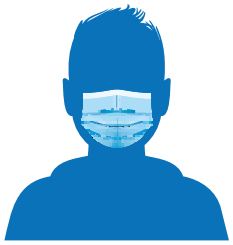
Please find below a table outlining the total amount of recorded CO2e (carbon equivalent) used in operating the Trust Estate (2019/20).

Table 5

Tons of CO2e	Community	New Cross	West Park	Cannock	Total
Electricity	138	5541	247	1668	7594
Gas	97	10077	468	1330	11972
Oil	0	93	3	11	108
Total	**235**	**15711**	**718**	**3009**	**19674**

The total annual carbon calculation has noted an increase of around 8% since last year due to an increase in electricity usage. There are many factors than can influence this, in particular with increasing the estate floor space and the provision of new services from the New Cross site, for example the Black Country Pathology Services. We would hope to see a return to normalised carbon usage in the next year, but again this will be subject to any increase/additional services and also any impact from the solar farm proposal. The Trust continues to look to investing in plans to support the reduction of energy consumption and the Sustainability Group will hope to shape this even further moving into the future to aid in meeting the NHS carbon targets.

Engagement with public, patient and stakeholders



Patient and public engagement and co-production

Despite the impact of COVID-19, throughout 2020/21 the Trust has continued to progress the three-year Patient Experience, Engagement and Public Involvement Strategy (2019-2022). This strategy sets out how the Trust would aspire to further improve patient experience, engagement and public involvement. Several initiatives had been implemented this year which focused on improved processes, co-production and continuous improvement.

Examples include:

- The ability to receive real-time patient experience feedback and monitoring across all Trust areas including in community/acute settings
- The publication of a quarterly newsletter 'Listen, Learn, Share' which provides information of actions taken and learning outcomes as a result of feedback received
- The development and maintenance of a community stakeholder database
- A refresh of the self-assessment against the NHS Improvement Patient Experience Improvement Framework to identify areas for improvement
- Piloted the NHS England Initiative of 'Always Events' within Paediatrics and designed key always events as part of a co-production approach with patients
- Ensured triangulation of patient experience with wider quality, safety, workforce and performance metrics – now visible on ward entrances of all inpatient areas
- Included stakeholders, patients and/or their carers to contribute and co-produce documents and initiatives to improve the patient experience
- Increased the ways and means of how patient feedback is obtained by ability to complete Friends and Family Surveys electronically and by scanning onto a QR Code
- **Observe and Act**, a critical-friend service improvement tool involving non-medical supporters, has been revised. The introduction of the Observe and Act initiative has been implemented as an e-learning package
- In terms of complaint outcomes, the Trust has continued to demonstrate a notable percentage increase on closed complaints not upheld and same notable reduction for closed complaints partially or fully upheld, when compared nationally. This data is supported by subsequent low numbers of our own complaint investigations being successfully appealed and upheld by PHSO
- Following the implementation of a specific volunteer services improvement plan, cohorts of community clinical volunteers supported the Trust throughout the year, some gaining paid employment as a result of volunteering
- The Patient Engagement Toolkit has been reviewed and updated to make it more accessible and visually engaging. Co-Production has been given more emphasis and a new appendix has been added on digital engagement which has become a key tool in the COVID-19 environment. The engagement champions have continued to meet virtually
- **Always Events**, a co-production and design framework, have now been introduced to a second team at West Park with others planned.

The Patient Experience Team has continued to work on EDS2 (Equality and Diversity Systems). Information has been collated from across the Trust about the engagement that has taken place. Examples of this are:

- The Neuro-Rehab Team at West Park: Worked with patients to run an 'inclusivity' programme to ensure that patients' specific needs across all protected categories are being met
- The Accessible Information Working Group: Similarly examined communication protocols to ensure that communication barriers to engagement are minimised to maximise patient and public participation
- The Sexual Health Team: Following patient comments the Sexual Health Team has desegregated patient waiting areas and adapted forms to be more reflective of the wide range of gender identities
- Learning Disability Team: Now offers an open referral system to patients and carers to access the team more readily
- Colorectoral Team: Responded to stated patient sensitivities around awareness of their 'stoma' status. This resulted in procedures, policies and protocols being changed to ensure even greater confidentiality and 'sensitive signposting' contacts being identified
- Children's Services: Introduced a 'Health Passport' to enable patients to participate in and contribute to greater care planning, with the passport informing the full range of health professionals to enable them to provide patient-centred care
- Trust magazine entitled 'Engagement Under Lockdown' to guide staff to explore alternative ways engaging with patients and community groups.

Patient stories

Patients and carers were again encouraged to express how it feels to receive care from the Trust by the sharing their 'Patient Stories'. Such stories provided the Trust with an opportunity to learn as an organisation, bringing experiences to life and making them accessible to other people. They can, and do, encourage the Trust to focus on the patient as a whole person rather than just a clinical condition or as an outcome. Patient stories are shown at Senior Managers Briefings and Trust Board sessions. During 2020/21, the stories shared included experiences of accessing stoke services, participating in a clinical trial for breast cancer and long-term recovery following treatment for ulcerative colitis.

Council of Members

The Council of Members, established in 2017, has continued to make strides by working together more effectively as a group and as individuals contributing to initiatives and meetings at the Trust. This group of committed individuals from our local community, have provided a patient perspective to the Trust on a range of important topics.

During 2020/21, the impact of COVID-19 meant that progress of the Council was paused and the level of active involvement in Trust work streams and external events was limited, although members have been active where possible, however we are happy to say that from July 2020 onwards we were able to pick up work again and resume meetings virtually.

Due to the COVID-19 situation we decided to also pause new elections for this year and are glad to say the existing Chair and Vice Chair were happy to stay in their roles to support us re-establishing the important work of the Council. Members have also been active outside of the Council meetings. The overall activity is summarised as follows:

Key Topics Covered by Council Meetings

- Sexual Health Services and patient engagement
- Trust response to COVID-19
- Equality Delivery System 2
- Trust Dementia Services

In relation to some of these topics, the Council received a number of presentations, followed by discussion and feedback to lead officers. Whilst these were the major items for consideration, the Council was routinely approached for its views on a whole range of day to day service delivery issues such as revision of patient obstetrics leaflets.

Member involvement in Trust work streams

Council members have participated in a range of Trust work groups and initiatives to provide a patient perspective in areas such as:

- Equality, Diversity and Inclusion Steering Group
- Complaints Review Panel
- Trust Research and Development Projects
- Trust Policy Group meetings
- Infection Control Committee
- Patient Information Boards
- Digital Innovation Group
- Reviewing patient leaflets
- Contributing to RWT research projects.

Membership base

Throughout the year, the Council have continued to attract interest from new members. During 2020-21 we have recruited an additional four members, and have had one member resign due to a new employment opportunity.

Serious incidents

Table 6

01/04/2020 to 31/03/2021

Category	01/04/2020 to 31/03/2021
Confidential Breach	4
Consent	1
Diagnostic	9
Infection (C.Diff) (COVID-19 related) (CPE) (MRSA) (MSSA)	 5 59 1 2 1
Maternity	4
Never Event (Oxygen related)	1
Pressure Ulcers (Community acquired) (Hospital acquired) (Corporate acquired) (Trust acquired)	 3 12 1 2
Slip / Trip / Fall (resulted in serious harm)	5
Sub Optimal Care	3
Treatment Delay	14
Unexpected Death (coded as pending at this time)	1
VTE	129
Total	**235**

The Trust reviews serious incidents to identify themes for redress and improvement. Over 2020/21 top reported categories were diagnosis, infection control-related, pressure ulcers and treatment delay. Within these categories some themes identified included communication, policy and human factors. The Trust will undertake further reviews where appropriate in order to develop a targeted action plan for continuous improvement.

Workforce

The Royal Wolverhampton NHS Trust is one of the largest NHS Trusts in the West Midlands, and the largest employer within the local community, employing ca. 10,300 substantive staff providing primary, acute and community services and we are incredibly proud of the diversity of both our staff and the communities we serve. We are building a workforce that can help us to fulfil our values, improve quality of care for patients, and solve the health care problems of tomorrow. We are passionate about the value that diversity of thinking and lived experience brings in enabling us to become a learning organisation and leader in delivering compassionate care for our patients. This is reflected in our latest staff survey results. We have achieved numerous awards including The Nursing Times Best Diversity and Inclusion Practice, Best UK Employer of the Year for Nursing Staff in 2020 and achieved Gold standard for the Defence Employer Recognition Scheme as well as being shortlisted as a finalist in the 'Leading the way as an employer' Step into Health awards.

The Trust is a supportive working environment committed to creating flexible working arrangements that suit your needs and as such will consider all requests from applicants who wish to work flexibly. Our latest staff survey results show that we have maintained our positive staff engagement levels over the last five years together with an increase in staff advocacy rates.

The Trust employs a significant proportion of our workforce from the Wolverhampton postcode and we continue to be committed to strengthening our networks with local partner organisations, schools, colleges and universities to provide a range of opportunities for employment at all levels including apprenticeships, entry level roles and healthcare career pathways.

Headcount, gender, disability and ethnicity

(Tables 8, 9, 10 & 11)
Headcount 31 March 2021

Staff type	Female	Male	Grand Total
Apprentice	20	7	27
Other Staff	7969	1438	9407
Student Nurse	67	4	71
Trust Board - Execs	3	7	10
Trust Board - Non Execs	4	5	9
Medical and Dental	483	674	1157
VSM / Band 8a+	399	165	564
Grand Total	**8945**	**2300**	**11245**

Staff numbers by proportion
(Trust board, senior managers and other staff

Staff type	Female	Male
Apprentice	74.07%	25.93%
Other Staff	84.71%	15.29%
Student Nurse	94.37%	5.63%
Trust Board - Execs	30.00%	70.00%
Trust Board - Non Execs	44.44%	55.56%
Medical and Dental	41.75%	58.25%
VSM / Band 8a+	70.74%	29.26%
Grand Total	**79.55%**	**20.45%**

Disability

The proportion of employees recorded on ESR, having declared that they have a disability has further increased by 0.08% (1.36% in 2010). Our Disability and Long-Term Conditions Employee Voice Group has become more established in this last year and one of the objectives of the group is to look at ways of engaging with and encouraging more individuals to declare status; this will be through various channels of communication and engagement sessions and story boards to demonstrate the value of sharing more information with the Trust, e.g. improved reporting, training, policies and procedures.

Declaration Status	%
No	70.70%
Not Declared	27.21%
Prefer Not To Answer	0.56%
Unspecified	0.09%
Yes	1.44%
Grand Total	**100.00%**

Ethnicity

The ethnic demographic of the Trust's workforce as at 31 March 2021 is 32.65% (compared to 30.75% in the previous year); the proportion of White ethnic staff is lower compared to the previous year (reported as 69.25%).

Ethnicity	%
African	4.23%
Asian	3.48%
Bangladeshi	0.43%
Caribbean	3.17%
Chinese	0.49%
Indian	11.80%
Mixed White	2.11%
Other Black	0.63%
Other Mixed	0.45%
Other/Not Known	3.59%
Pakistani	2.22%
White	67.35%
Nigerian	0.05%
Grand Total	**100.00%**

Staff catchment area

At the end of the financial year March 2021, 59% of the Trust's workforce reside within a WV postcode (Source: Electronic Staff Record system); there has been no change to this from the previous year.

Sickness absence

[Sickness absence – also applies to Section C Financial Statements]

Ethical procurement, human rights (anti-slavery) in contracted services

The Trust sources its procurement function the Integrated Supplies & Procurement Department (ISPD) based at University Hospitals North Midlands which is committed to:

Utilise the Sustainable Procurement Flexible Framework (SPFF) to facilitate the procurement of goods and services in a more innovative, sustainable manner.

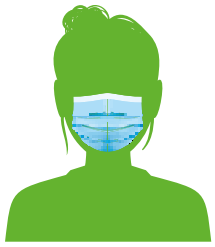
This self-assessment mechanism allows each Trust to measure and monitor progress on sustainable procurement over time. All Trusts are aiming for year on year improvements to achieve and work through the actions in the SPFF, working through the levels from Foundation Level 1 to achieve Lead Level 5 by 2021-22.

Purchase more goods from sustainable sources, with a focus on those from local, ethical and Fair-Trade Suppliers, reducing carbon emissions and improving labour standards are very important areas for the health and social care sector as a whole. All Trusts have an ethical duty to protect and promote health and wellbeing and contract with suppliers of goods and services that operate in a socially responsible way with good environmental practices and employment practices. The Trusts will use Ethical Procurement for Health (EPH) to support this. Products used will have sustainable specifications using Government Buying standards and Green Public Procurement criteria. The Trusts aim to use their buying power to generate social benefits and consider economic, social and environmental wellbeing when negotiating public service contracts as enshrined in the Public Services (Social Value) Act 2012.

In addition, the NHS Terms & Conditions of Contract for goods & services specify the following terms for suppliers to adhere to in relation to Equality & Human Rights:

Ensure that (a) it does not, whether as employer or as provider of the services, engage in any act or omission that would contravene the Equality Legislation, and (b) it complies with all its obligations as an employer or provider of the services as set out in the Equality Legislation and take reasonable endeavours to ensure its staff do not unlawfully discriminate within the meaning of the Equality Legislation; in the management of its affairs and the development of its equality and diversity policies, cooperate with the authority in light of the authority's obligations to comply with its statutory equality duties whether under the Equality Act 2010 or otherwise. The supplier shall take such reasonable and proportionate steps as the authority considers appropriate to promote equality and diversity, including race equality, equality of opportunity for disabled people, gender equality, and equality relating to religion and belief, sexual orientation and age; and the supplier shall impose on all its sub-contractors and suppliers, obligations substantially similar to those imposed on the supplier.

Anti-corruption, anti-bribery and anti-fraud work



This Trust is committed to providing a zero-tolerance culture to fraud, bribery and corruption whilst maintaining an absolute standard of honesty and integrity in dealing with our assets. We are committed to the elimination of fraud and illegal acts within the Trust. We have a team of fully accredited Local Counter Fraud Specialists (LCFS) to ensure the rigorous investigation of reported matters of fraud, bribery or corruption and the pursuance of redress for financial losses stemming from such acts, and the application of disciplinary sanctions or other actions, including consideration of criminal sanction, as appropriate. We adopt best practice procedures to tackle fraud, bribery and corruption, as recommended by the NHS Counter Fraud Authority.

The Trust has implemented a range of policies, procedures and work programmes that are designed to reduce the likelihood of fraud and corruption and detect fraud plus we annually assess the Trust's risk exposure to both internal and external fraud.

Throughout 2020/21 awareness of fraud and bribery and those policies in place has been raised across the Trust and this work will be ongoing in 2021/22. All referrals of fraud, bribery and corruption were investigated and where appropriate, cases were referred for disciplinary consideration and criminal sanction if proportionate.

The NHS Counter Fraud Authority's Counter Fraud Function Standard Return Self-Review assessment for provider health bodies was undertaken by the LCFS on behalf of the Trust for the anti-fraud, bribery and corruption work conducted during the period 1 April 2020 to 31 March 2021, inclusive. The NHS Counter Fraud Authority will provide an overall assessment of the Trust's counter fraud arrangements in due course.

The Chief Finance Officer has overall responsibility for counter fraud within the Trust and reports on activity are submitted to the Audit Committee.

Staff engagement

The Trust's staff engagement levels have remained fairly consistent and continue to be above the national average of comparator organisations (as shown in the latest NHS Staff Survey results) and this is consistent across the majority of the staff survey themes. We are committed to and continuously strive to provide the right conditions for our staff and in turn improve patient experience and outcomes and this is confirmed through a further notable increase in staff responding that they would recommend the Trust as a place to work (75.5%) and as a place to receive treatment (84.4%). In addition, we have seen notable improvements in the staff survey for the areas of health and wellbeing and morale, which is particularly positive during the COVID-19 pandemic and is a result of the additional support, communication and engagement provided across the whole workforce.

The Trust's commitment to delivering high quality patient care is dependent on having healthy staff who feel supported. We believe that supporting staff wellbeing in the workplace is an important shared responsibility, which is enabled through the Trust's strategic approach to workplace health and wellbeing and covers the following five wellbeing themes: career, mental and emotional wellbeing, physical, financial and community and social wellbeing. This is underpinned by a high-level action plan with a number of key priorities particularly in relation to physical and emotional wellbeing.

The key objective during 2020/21 was to continue to further embed the Trust's health and wellbeing agenda and progress a variety of approaches. Protecting the health and wellbeing of our staff has been a top priority throughout the COVID-19 pandemic, during which everyone has been continuously challenged and tested - both physically and emotionally. Our 2020 staff survey results have shown a further increase in the number of staff who have stated that the Trust takes positive action on health and wellbeing (a 4% increase compared to 2019).

In supporting our staff wellbeing, the Trust put in place a dedicated website accessible for all staff with a variety of information and resources to help individuals at work and at home. Additionally, a suite of information for managers/leaders providing techniques and guidance on how to best support their teams was implemented. Our trained mental health first aiders and health and wellbeing champions continue to be a crucial resource across the organisation.

To further strengthen our approach to staff engagement, we are continuing to move forward this year with the Staff Survey Oversight group with representation from each division, where results are discussed and progress against action plans is reviewed; in addition to providing a forum to share and learn.

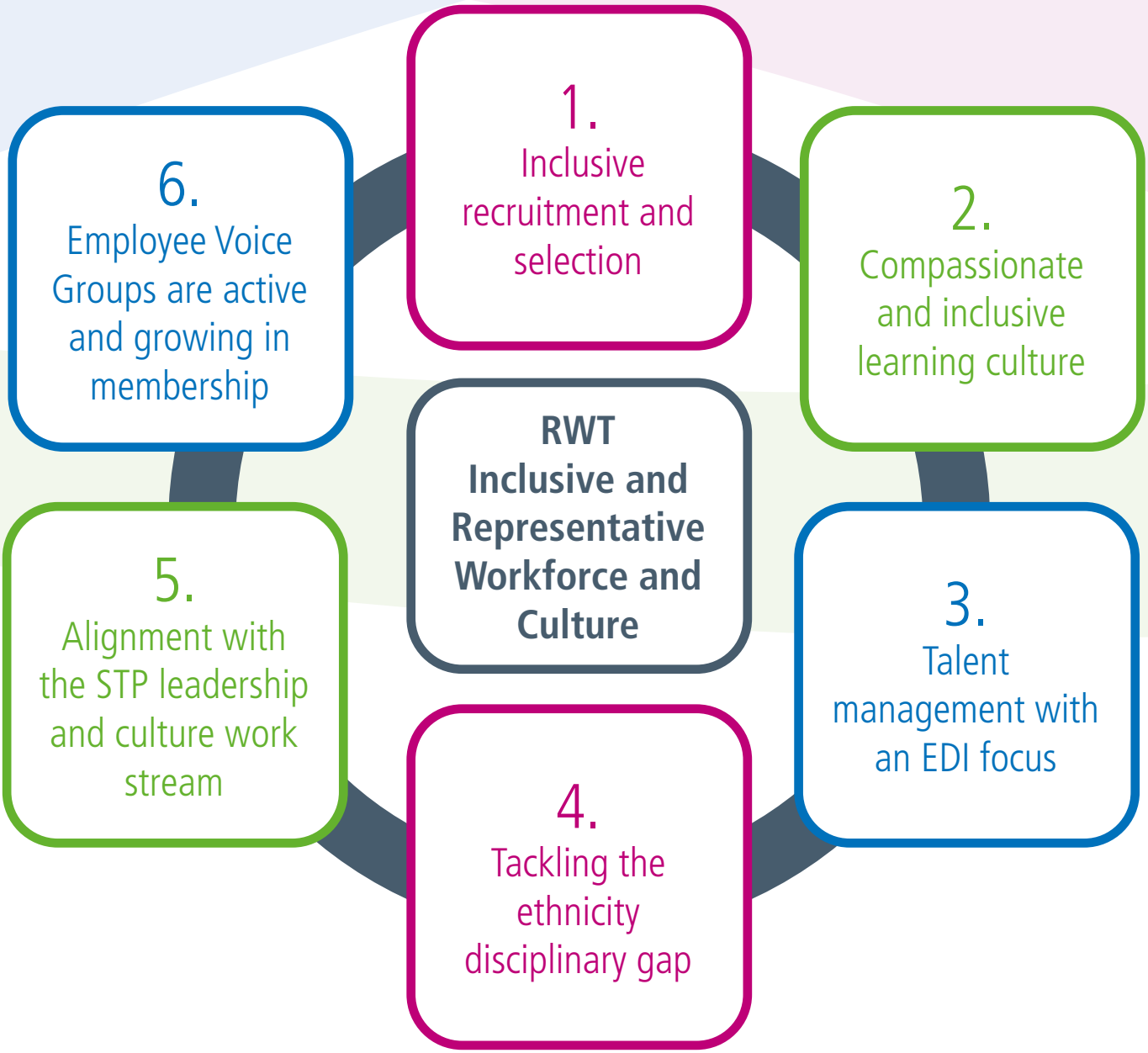
Diversity and inclusion in the workforce

The importance and focus on equality, diversity and inclusion has been brought to the forefront during the COVID-19 pandemic and there has been a long-standing national commitment to reduce ethnic disparities across the NHS workforce pipeline as highlighted through the national Workforce Race Equality Standard (WRES) data. Improving the experiences and representation of Black, Asian and Minority Ethnic Staff (BAME) is a key feature within the NHS People Plan and Model Employer directive.

As a Trust, we have put much focus on staff engagement and wellbeing and equality, diversity and inclusion over this last year; this has included continuing engagement with the Employee Voice Groups, listen and learn sessions with members of the Executive team and senior leaders across the organisation and marking key events.

The Royal Wolverhampton NHS Trust is taking further proactive measures to meet its workforce and equality challenges and we have developed a refreshed two-year Equality, Diversity and Inclusion (EDI) Delivery Plan focusing on around six key strands which have been identified as priorities to ensure success:

1. Inclusive recruitment and selection
2. Compassionate and Inclusive learning culture
3. Talent management with an EDI focus
4. Tackling the ethnicity disciplinary gap
5. Alignment with the STP leadership and culture work stream
6. Employee Voice Groups are active and growing in membership



Regulation 8, schedule 2 2017/328 Declaration of facility time

Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
1	2

Percentage of time spent on facility time

Percentage of time (%)	Number of employees
0%	
1-50%	
51%-99%	
100%	2

*There are 2 part-time employee's spending 100% of their part-time hours on Union work.

Percentage of pay bill spent on facility time

Provide the total cost of facility time	£40,131
Provide the total pay bill	£462,321
Provide the percentage of the total pay bill spent on facility time, calculated as: (Total cost of facility time / total pay bill) x 100	0.01%

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%.

Volunteer services

The Trust is fortunate to have the support of volunteers, who are unpaid members of our local community who offer their time willingly to help.

As always, we hold provision of a positive patient experience at the forefront of our volunteering activity, and we aim to place volunteers into roles which complement, but do not replace, paid members of staff. Volunteers add an important 'extra' factor to helping us provide a positive patient and visitor experience at RWT.

2020/21 certainly was a year of huge change within voluntary services, our existing voluntary workforce prior to the COVID-19

pandemic, were stood down due to a combination of factors. As a result, the Trust decided to hold recruitment for a COVID-19 specific 'Community Clinical Volunteer' role to provide much needed support to our clinical area.

We successfully managed to recruit 120 volunteers by May 2020 an allocated people to ward areas. Volunteers were provided with training in bed making, nutrition and serving refreshments, dementia, and infection prevention.

The role of the volunteers was extremely successful. While volunteers were deployed initially into areas of greatest need to perform essential tasks such as bed making, volunteers also got involved with examples of truly enhancing the patient experience, including helping set up a new patient lounge, helping to create and facilitate a VE Day socially distanced tea party celebration, and helping patients undertake video calls with loved ones. Later we expanded the roles to include supporting the COVID-19 swab hub, internal vaccination hubs, virtual COVID-19 ward, a discharge follow up call scheme, and an activity programme at our rehabilitation hospital.

During recruitment, we particularly increased the number of younger volunteers supporting the Trust by linking in with local schools and colleges.

A further recruitment for clinical volunteers took place in late 2020 and we received a further 100 applications. Our successful volunteers program has gained national attention.

Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

Guidance for Quality Accounts remains in place nationally, which outlines the requirements with respect of the format, content and reporting arrangements for the annual Quality Accounts. The Trust used this guidance to ensure that its requirements were included in the Trust's Quality Account 2020/2021.

The Trust's quality priorities for 2020/2021 were selected as part of a consultation process with our staff and external stakeholders. In addition, the Trust reviewed what patients and members of the public said about us through national and local surveys, in-patient feedback received through complaints, compliments and the Friends and Family Test. In addition, various national and local guidance and feedback from the Care Quality Commission were considered.

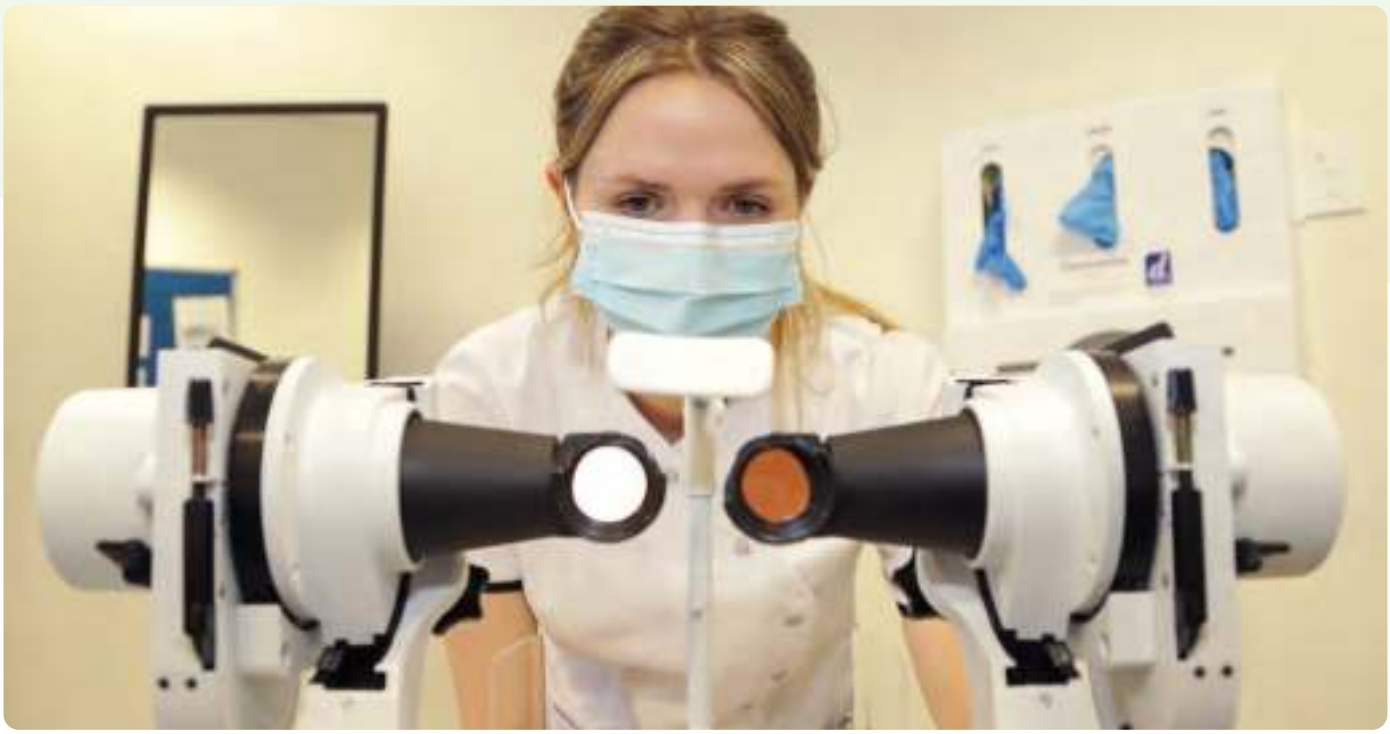
A variety of data reporting systems remained the source of information for the Quality Account 2020/21. For example, the incident and complaints data was extracted from Datix (incident reporting system). In addition, information was validated with individual leads, for example, the governance team, patient experience team, infection prevention and control lead, performance team. In terms of the elective waiting time data, the Trust has continued to employ a robust process of validation prior to submission. This involves an automated process which produces a data extract from Patient Administration System (PAS) to outline patient that have been listed for surgery, which is validated for duplicates and anomalies for investigation and correction. Following this, the data is reviewed further by a validation team to ensure patient records are accurate, up to date and reflect individual patient journeys and pathways. This process is repeated up until the point of submission to ensure any data lag issues are resolved in a timely manner.

Each year, a draft version of the Quality Account is approved by directors via the internal governance processes prior to being shared with the Local Authority's Overview and Scrutiny Committee, Wolverhampton Healthwatch and Clinical Commissioning Group. In addition, the Quality Account is subject to a limited assurance review by the Trust's independent auditors prior to the final version being shared with the Trust Board for approval and subsequently published.

The Quality Account outlines the progress made against the 2020/21 objectives together with details of the key objectives for the forthcoming year. These objectives have been set based on the priorities of the Trust, considering external accreditation, variety of surveys, CQC inspection outcomes, key improvement priorities and views of the staff, patients, public and our key stakeholders.

Note:

The Quality Account was to be published by no later than 30 June 2021 and as a result, the final version presented to Trust Board on 1 June 2021. However, please note the caveat with regards to the National Inpatient Survey 2020.



The Trust charity

Our charity makes a real difference to our patients, their families and the staff that treat them, above and beyond the services provided by the NHS.

We aim to support the Trust to realise its vision to be an NHS organisation that continually strives to improve the outcomes and experiences of the communities we serve.

We support the Trust's work by providing:

- Additional facilities and an improved environment
- Additional equipment that can make a real difference to patient care
- Opportunities for staff training above and beyond their mandatory training
- Opportunities to further medical knowledge through research.

In March we saw a very challenging and unprecedented time within the NHS; the fight against COVID-19. Many of our supporters came together to help raise vital funds that would make things easier for our patients and staff. We are truly grateful for all of their support.

As a charity we have done our very best to respond positively to the impact of COVID-19 on our patients and staff. We have been able to pass on the benefits of significantly increased funding and gifts directly to those needing support.

Purchases from charitable funds donated to the charity during 2020-2021 include the following items:

Comfort packs for patient welfare due to restricted visiting

- iPads to assist patient communication with their loved ones
- Special thank you card, £25 voucher and pin badge for all staff and volunteers for their amazing hard work and dedication throughout the pandemic
- Picnic benches so our hardworking staff can enjoy their breaks in the fresh air after wearing their PPE.

The annual report and accounts of the Trust Charity will be published in the late summer 2021, where you can find further information and you can find out more about out work.

The Royal Wolverhampton
NHS Trust Charity

Registered Charity No. 1059467

B – Accountability report

B1 – Corporate governance report

Directors report

The Directors of the Trust

During the year 2020/21 and up to the signing of the Annual Report and Annual Accounts, the Accountable Officer for the Trust was Prof. David Loughton, CBE and the Trust Chairperson was Professor Steve Field. The Trust Board comprised Prof. Loughton and Prof. Field and the following Directors (any with less than a full year of Board membership are denoted accordingly):

Prof. A-M Cannaby	Chief Nursing Officer (v)
Mr A Duffell	Chief People Officer
Mr J Dunn	Non-Executive Director (from 17 February 2021)
Mr R Dunshea	Non-Executive Director, Senior Independent Director, Chair of Audit Committee Chair of Innovation & Research Committee
Ms R Edwards	Non-Executive Director, Chair of Quality Governance Assurance Committee
Mr S Evans	Chief Strategy Officer
Ms S Evans	Director of Communication and Stakeholder Engagement (from Jan 2021)
Prof. S Field	Chair, Non-Executive Director
Mr J Hemans	Non-Executive Director, Chair of Workforce Committee
Prof. D Loughton CBE	Chief Executive Officer (v) Chair of Management Committee
Prof. S Mahmud	Chief Innovation, Integration and Research Officer
Ms M Martin	Non-Executive Director, Chair of Finance and Performance Committee Chair of Remuneration Committee
Ms G Nuttall	Chief Operating Officer (v)
Dr J Odum	Chief Medical Officer
Ms D Oum	Non-Executive Director (to 3 October 2020)
Ms T Palmer	Director of Midwifery (from Jan 2021)
Prof. A Pandyan	Associate Non-Executive Director
Ms S Rawlings	Non-Executive Director, Chair of Trust Charity
Mr M Sharon	Strategic Advisor to the Board
Mr K Stringer	Chief Financial Officer/Deputy Chief Executive (v)
Prof. L Toner	Associate Non-Executive Director Chair of Clinical Ethics Committee

The roles and activities of the Trust Board committees are covered in detail in the Annual Governance Statement (section B1 of this report).

During 2020/21 the Trust Board comprised the Chairman; the Chief Executive; four Executive Directors (Chief Officers) voting and three non-voting; five voting and two non-voting Non-Executive Independent Directors; and was supported by three additional Directors (two attending the Board) and a Strategic Advisor.

Each voting Chief Officer (Executive Director) and Independent Non-Executive Director has an equal vote on the Trust Board. Executive Directors are responsible to the Trust Board for the delivery and performance for services within their portfolios.

Independent Non-Executive Directors provide challenge and a level of independent scrutiny to decision-making, implementation and reviewing organisational performance.

Their backgrounds and experience provide a balance of skills to provide a level of challenge across the range of activities of the Trust Board. The Chief Executive Officer is the Accountable Officer to Parliament.

During 2020-2021 the Trust Board met monthly and virtually, except in September 2020 and January 2021 (as scheduled in the Trust Board Timetable), conducting most of its business in public and allowing time for the press, public and other observers to lodge questions to be asked of the Directors at or after each meeting. In addition, the Trust Board undertook monthly development sessions and twice monthly Non-executive Director Briefings.

A fuller account of the Trust Board's work is provided in the Annual Governance Statement.

The appointment of new Non-executive Director and Associate Non-Executive Directors

John Dunn, a Non-executive Director at Walsall Healthcare NHS Trust, was appointed (as replacement for Danielle Oum, Chair at Walsall Healthcare NHS Trust to 1 March 2021 resigning as of 3 October 2020) and joined the Trust Board as Non-Executive Director with effect from 17 February 2021.

The appointment of new Directors (attending and non-attending) and the shared Chief Medical Officer role

The Chief Executive appointed to three Director roles – Ms Sally Evans as Director of Communications and Stakeholder Engagement (attending Board) from Jan 2021, Ms Tracy Palmer as Director of Midwifery (attending Board) from January 2021 and Ms Louise Nickell as Director of Education (non-attending) from January 2021.

Board membership

Prof. David Loughton CBE - Chief Executive

Appointed 2004

Professor Loughton joined our Trust in 2004 having had extensive experience as a Chief Executive within the NHS. During his career he has developed a new medical school with Warwick University and achieved financial close on a £400 million new hospital Private Finance Initiative (PFI). He has now turned around one of the 17 most financially challenged Trusts in the NHS, whilst improving the quality of care provided to patients. Professor Loughton is a member of the National Institute for Health Research Advisory Board.

Board Attendances in 2020-2021: 9/10

Declaration of interests

- Health policy adviser to the Labour and Conservative Parties ended 01/12/2020
- Dementia Health and Care Champion Group – Member ended 01/12/2020
- National Institute for Health Research – Member of Advisory Board
- Chair of West Midlands Cancer Alliance (from 06/06/2018).

Prof. Steve Field CBE - Chairman of the Board

Appointed 1 April 2019

Professor Field holds a number of roles at various organisations including Chair at Walsall Healthcare NHS Trust, Trustee at Nishkam Healthcare Trust and a Trustee for Pathway Healthcare for Homeless People.

Prior to his role of chair, he was Chief Inspector of General Practice, Primary Medical Services and Integrated Care at the Care Quality Commission (CQC). He has held several board positions in the NHS including, Deputy National Medical Director at NHS England, Regional Postgraduate Dean for NHS West Midlands and Chairman of the NHS Inclusion Health Board at the Department of Health. He also held the position of Chairman of The Royal College of GPs, and has been a faculty member at the Harvard Macy Institute of Harvard University in the USA. He has been awarded a number of honorary degrees and also holds academic appointments at the University of Birmingham and the University of Warwick.

Board Attendances in 2020-2021: 10/10

Declaration of interests

- Nishkam Healthcare Trust Birmingham – Trustee
- Chair, Walsall Healthcare NHS Trust
- Honorary Professor - University of Birmingham
- Honorary Professor – University of Warwick
- Director of EJC Associates
- Trustee for Charity, Pathway Healthcare for Homeless People.

Professor Ann-Marie Cannaby - Chief Nurse and Lead Executive for Safeguarding

Appointed April 2018

Ann-Marie joined the Board at Wolverhampton in April 2018. Ann-Marie is a visiting Professor at Birmingham City University, who has amassed extensive experience working both nationally and internationally in senior nursing leadership roles.

She spent five years as Chief Nursing Officer at Hamad Medical Corporation, the main healthcare provider in Qatar. She was responsible for the organisation's 10,000 nursing and midwifery staff across eight hospitals, a number of community health facilities and the national ambulance service. Before her move to the Middle East, Ann-Marie spent over seven years at University Hospitals Coventry and Warwickshire NHS Trust, a 1,300-bed acute provider spread across two sites with a budget of £640m, where she progressed to the dual role of Chief Nursing Officer and Chief Operating Officer.

Prior to this she spent a number of years at University Hospitals of Leicester NHS Trust in a variety of frontline nursing and leadership posts. Ann-Marie has successfully transitioned into different health systems and environments throughout her career. She has extensive experience in working in Accountable Care Systems (ACS), most recently the Canterbury ACS in New Zealand.

Ann-Marie offers an extensive professional, operational and executive background combined with a strong academic portfolio, she is actively involved in research and education holding a Masters and a PhD, with deep experience in curriculum development.

Board Attendances in 2020-2021: 9/10

Declaration of interests

- Birmingham City University – Professor of Nursing Sciences (to December 2020)
- Visiting Professor of Nursing Sciences - Birmingham City University (from January 2021)
- Royal College of Nursing – Member
- Warwick University – Research fellow (Honorary) ceased 01/04/20
- Higher Education Academy – Teaching Fellow
- Ann-Marie Cannaby Ltd. – Director
- Leicester and Leicestershire Photographic Society – Member ceased 07/02/20
- La Trobe University, Victoria, Australia - Honorary Visiting Fellow
- Visiting Professor Staffordshire University.

Alan Duffell - Chief People Officer

Appointed April 2017

Alan has wide experience within the NHS, incorporating OD, learning & development, leadership & management development, as well as other HR related roles. He joined the board of Wolverhampton in April 2017 after previously holding the position of Director of HR & OD at Leicestershire Partnership NHS Trust, where he had been for five years, with board level responsibility for a wide-ranging workforce portfolio, as well as H&S and Business Continuity. Prior to this, he was the Director of Workforce and Learning within the Black Country Partnership NHS Foundation Trust and at that time was also a director for Skills for Care, representing the NHS. Prior to joining the NHS, Alan was in the Royal Air Force spanning a range of roles including avionics engineer, training & development, and leadership development. He holds membership of the Chartered Institute of Personnel & Development (CIPD), Chartered Management Institute (CMI) and holds an MSc in Human Resource Development.

Board Attendances in 2020-2021: 10/10

Declaration of interests

- Member of Chartered Management Institute
- Member of the CIPD (Chartered Institute for Personnel and Development)
- Member (unpaid) of the UK & Ireland Healthcare Advisory Board for Allocate Software (Trust Supplier)
- System Workforce Lead BC&WB System Workforce lead (from 01/01/21).

Prof. Sultan Mahmud - Chief Innovation, Integration and Research Officer

Appointed September 2014

Sultan Mahmud has been in the NHS for 19 years and has been an NHS board director for eight years. He has undertaken senior roles in both provision and commissioning arms of the NHS including clinical and business informatics, programme management, performance management, primary and secondary care commissioning. A keen technologist and innovator Sultan lectures part time at various universities, nationally and internationally on healthcare innovation, information management and value in healthcare. Sultan has also enjoyed a spell in the pharmaceutical industry working in medical regulatory affairs.

Board Attendances in 2020-2021: 9/10

Declaration of interests

- Member of the Advisory Board for the Centre for Health and Social Care Leadership, HSMC, University of Birmingham.

Gwen Nuttall - Chief Operating Officer

Appointed 2012

Ms Nuttall has over 20 years' experience working across a diverse range of acute hospitals, having previously worked for local Government.

Gwen has worked in various management roles at The Chelsea & Westminster Hospital, Bart's and The London NHS Trust and more recently she was the Chief Operating Officer at West Suffolk Foundation Trust Hospital for eight years.

Board Attendances in 2020-2021: 8/10

Declaration of interests

- Calabar Vision 2020 Link – Trustee (from 03/12/2018).

Dr Jonathan Odum - Chief Medical Officer

Appointed 2011

Dr Odum qualified from Birmingham University in 1984 and his post graduate training and studies were undertaken in the West Midlands (1984-91) and Adelaide, South Australia (1991-93). He was awarded a Sheldon Research Fellowship by the West Midlands Regional Health Authority in 1988 and following completion of the research his thesis was awarded an MD by the University of Birmingham in 1993.

He took up post as a Consultant in General Internal Medicine and Nephrology at New Cross Hospital Wolverhampton in 1993. His clinical interests include diagnosis and management of hypertension and pathophysiological mechanisms underlying and treatment of glomerular disease. Dr Odum was elected as a fellow of the Royal college of Physicians (RCP) in 1999 and has been an MRCP PACES examiner from 1999 to the present day.

He has a significant interest in service development and as Clinical Director for Renal Services (1995-2005) was responsible for the expansion of renal services at Wolverhampton into Walsall and Cannock and the opening of the satellite Haemodialysis units at Walsall and in Cannock Chase Hospital. Dr Odum has held several medical managerial positions in the Trust including Clinical Director of Medicine, Divisional Director posts from 2003-11 and was appointed into the post of Medical Director from April 2011. Within the Royal Wolverhampton NHS Trust, Dr Odum is the Responsible Officer for revalidation of doctors, the Caldicott Guardian and the Medical Director of the West Midlands LCRN.

Board Attendances in 2020-2021: 9/10

Declaration of interests

- Private out-patient consulting and general medical/ hypertension and nephrological conditions at Wolverhampton Nuffield average time spent 1-2 hours/ week maximum
- Chair of ICS People Board (from 01/01/21).

Kevin Stringer - Chief Financial Officer

Appointed 2009

Mr Stringer is a qualified accountant with the Chartered Institute of Management Accountants (CIMA) and holds a Masters qualification in Business Administration (MBA). With over 25 years of experience in the NHS, with 13 of those years as a Board Director, he has experience of commissioning and provider organisations.

His experience covers –

Primary Care, Community Services and Commissioning (with successor organisations being Walsall CCG and Birmingham cross-city CCG)

Secondary and Tertiary Care (at University Hospitals of Coventry and Warwickshire, Sandwell and West Birmingham Hospitals)

Specialist Secondary Care (Birmingham Children's Hospital Foundation Trust where he helped the Trust secure FT status)

Regional NHS Planning and Oversight (West Midlands Regional Health Authority)

His role is to provide professional advice to the Board and wider Trust to ensure delivery of the Board's financial strategy, key statutory financial targets and ensure good internal control.

He is a member and advocate for Healthcare Financial Management (HFMA) having been a past Chairman of the West Midlands Branch where he is now the Treasurer.

Board Attendances in 2020-2021: 10/10

Declaration of interests

- Treasurer, West Midlands Branch – Healthcare Financial Management Association
- Member of CIMA (Chartered Institute of Management Accountants)
- Midlands and Lancashire Commissioning Support Unit – brother in law is the Managing Director.

Michael Sharon - Strategic Advisor to the Trust Board

Appointed 1 January 2016, revised role from 1 October 2019.

Mike commenced his working life as a hospital porter. What has stayed with him is a firm belief in the difference we can all make as individuals, no matter what our role, to the wellbeing of patients. After a long spell at Guy's and St Thomas' in operational management and in strategy, Mike became CEO of a GP company providing services to practices, followed by time as a PCT CEO.

Subsequently Mike has been a Director at University Hospital Birmingham FT and at Sandwell and West Birmingham Trust where he was acting CEO for short time. Between these roles Mike has spent a year working in a teaching hospital in Chicago, supported 37 GP practices to create a Federation, set up the Birmingham and Solihull Lift Company, and led two large health economy wide strategic change programmes. Mike really does enjoy spending time with his teenage children and also walking in the Lake District.

Board Attendances in 2020-2021: 10/10

Declaration of interests

- Member of the Liberal Democratic Party
- Wife works as an independent trainer, coach and councillor. Some of the work is for local NHS bodies (excluding RWT).

Roger Dunshea - Non-Executive Director

Appointed April 2014

Mr Dunshea has worked in the NHS in Scotland, Wales and England in a variety of positions including Staff Nurse, Project Manager, Clinical General Manager and Executive Director roles. Between 1997 and 2013 he was a Director with OFWAT (the economic regulator of the water sector in England and Wales) with responsibilities covering finance, information systems, human resources and procurement. He has been the Chair of Governors at a Central Birmingham High School and a Non-Executive Director with the Shrewsbury and Telford NHS Trust.

His other current roles are independent member of the Welsh Government's Education and Public Services audit and risk assurance committee and chair of the audit committee of the Geological Society. He is volunteer warden with Natural England. He is a Chartered Public Finance Accountant and Fellow of the Geological Society.

Board Attendances in 2020-2021: 10/10

Declaration of interests

- Geological Society of London – Member of Audit Committee (from 14/12/2018)
- Independent member of the Welsh Government Audit and Risk Committee for Education and Public Services.

Rosi Edwards - Non-Executive Director

Appointed as an Associate Non-Executive Director in July 2013, and became a Non- Executive Director with effect from November 2013

Rosi's experience has been in the public sector, in enforcement of health and safety legislation and promoting improved management of risk. She started her career as HM Inspector of Factories in South Yorkshire and moved to the West Midlands in 1987 to take up a post as operational policy lead for Robotics and Automation.

She has held a variety of senior management posts in the Health and Safety Executive including head of a regional team of specialist inspectors, occupational health physicians and scientists, head of Operational Policy for Engineering and Utilities, Operations Manager in the Construction Inspectorate, and finally Regional Director for Midlands, Wales and the South West.

Her career in HSE has given her extensive experience of assessing organisations' ability to manage risk. Since joining the Board, she has been appointed by the Care Quality Commission as an Executive Reviewer, taking part in Well-Led inspections of NHS Trusts. She is a consultant on Occupational Health and Safety for the Organisation for Economic Co-operation and Development, currently working on improving the Italian health and safety system.

Board Attendances in 2020-2021: 10/10

Declaration of interests

- Labour Party member
- Lay member of West Midlands ACCEA ceased 09/2019
- Daughter as an employee of Unite the Union takes part in union campaigning, including on the NHS
- President of Birmingham Health Safety and Environment Association
- Care Quality Commission Inward Secondment undertaking the role of Executive Reviewer
- OECD work for the Italian National Government, the Autonomous Province of Trentino, and Lombardy Regional government, as consultant advising on their systems for regulating occupational health and safety.

Sally Evans – Director of Communications and Stakeholder Engagement

Appointed January 2021

Sally joined the Trust as Head of Communications in October 2017 from NHS South Worcestershire Clinical Commissioning Group (CCG) after a decade working in communications in the NHS. Having worked across a range of NHS organisations including acute, mental health, community and commissioning in various communications roles, Sally brings a wealth of experience in the public sector.

Joining the NHS in 2007 as a Communications Assistant at The Dudley Group NHS FT, Sally moved to the Black Country Partnership NHS FT, then progressed to NHS South Worcestershire CCG in April 2015 as Communications Manager, heading up three CCGS – South Worcestershire, Redditch and Bromsgrove, and Wyre Forest. Sally is qualified with a Post-Graduate Diploma in Public Relations, awarded by the Chartered Institute of Public Relations. Her portfolio includes crisis communications, reputational management, stakeholder engagement and the Trust's charity.

Board Attendances in 2020-2021: 2/2

Declaration of interests

- None declared for 2019-2021.

Simon Evans – Chief Strategy Officer

Acting from 1 October 2019, appointed from 1 February 2020

Simon has worked in the health and care sector for over 17 years and has held a number of senior management positions. His roles have covered: strategic and service-level planning, performance management, business development, transformation and programme management. He holds a Masters Qualification in Business (MBA) from Aston Business School along with an Honours Degree in Business Studies.

Immediately prior to joining the Trust, he was QIPP Programme Director for Wolverhampton City Primary Care Trust, where he led on the transformation and planning agenda, working closely with GPs and primary care clinicians. He has also worked in corporate planning and scrutiny for a local authority and has led on a number of projects involving partnership working with primary, secondary and local government sectors.

Simon spent nearly eight years working in various locations across the UK as a senior manager for Marks and Spencer and IKEA. During this time, he helped develop the 10-year growth strategy for IKEA UK and was a store manager for M&S.

He has a passion for organisational and personal development and has a post-graduate diploma in Human Resource Development. He has lectured on Organisational Behaviour and Organisational Change for Staffordshire University and is a regular guest lecturer for the University of Wolverhampton.

Board Attendances in 2020-2021: 9/10

Declaration of interests

- None declared for 2020-2021.

Junior Hemans - Non-Executive Director

Appointed May 2015

Mr Hemans has significant years of experience within the public and voluntary sectors. He previously worked for the Housing Corporation for 10 years as a regulation manager and as a consultant for PricewaterhouseCoopers for ten years.

Junior was a founding member and the first treasurer of the African Caribbean Community Initiative Mental Health Project, which provides support to individuals and families that are experiencing mental health issues. He has also served as treasurer to the West Midlands Caribbean Parents & Friends Association and to the Heath Town Senior Citizens Welfare Project.

Junior currently runs his own small consultancy and is a property developer / landlord. He specialises in governance, business start-up, business development and social housing and regeneration. Junior is also a visiting lecturer at the University of Wolverhampton Business School, lecturing in strategic management, marketing, leisure and operations.

In February 2021, Junior was appointed as a NED of Walsall Healthcare, serving as a joint NED to both Trusts as they develop a closer strategic collaboration. Junior is now Chair of both Royal Wolverhampton NHS Trust and Walsall Healthcare Trust People & Organisation Development Committees.

Board Attendances in 2020-2021: 8/10

Declaration of interests

- Libran Enterprises (2011) Ltd – Director
- Tuntum Housing Association (Nottingham) – Chair of the Board
- Wolverhampton Cultural Resource Centre – Chair of the Board
- Prince's Trust - Business Mentor
- Kairos Experience Ltd – Company Secretary
- Member of Labour Party
- Wolverhampton University – visiting lecturer
- University College Birmingham – visiting lecturer ceased 28/09/20
- Non-executive Director, Walsall Healthcare NHS Trust commenced 01/02/21.

Mary Martin - Non-Executive Director

Appointed July 2013

Mary Martin is an experienced Non-Executive Director having served on the boards of commercial organisations, charities and NHS Trusts. Her business focus is to concentrate on the strategic issues; engagement with stakeholders; the development of new ways of working and the efficient management of funds, people and assets. Mary is also a Non-Executive Director of Walsall Healthcare NHS Trust and a trustee of The ExtraCare Charitable Trust and two major Midlands based arts charities – B:Music and Midlands Art Centre.

She worked for twenty-five years in the accountancy profession and was a Partner with Arthur Andersen, one of the largest international accounting practices. She then held a variety of executive positions including working with Advantage West Midlands; a private venture fund manager focussed on technology start-ups and finally as Pro-Vice Chancellor of Birmingham City University. She is a Fellow of the Institute of Chartered Accountants and an Oxford University engineering graduate.

Board Attendances in 2020-2021: 10/10

Declaration of interests

- Martin Consulting (West Midlands) Ltd – Director / owner of business
- B:Music Limited – Trustee / Director, Non-Executive member of Board for the charity
- Midlands Art Centre – Trustee / Director, Non- Executive member of the Board for the charity
- Friday Bridge Management Company Limited (residential property management company)
- Extracare Charitable Trust – Trustee / Director, Non-Executive member of Board for the charity
- Non-executive Director, Walsall Healthcare NHS Trust commenced 01/04/21.

Danielle Oum - Non-Executive Director

Appointed 1 October 2019, resigned 3 October 2020

Danielle has more than 10 years' experience of leading public service business improvement and programme management and has also worked extensively in the private sector, building and leading international teams. Danielle's professional expertise is in stakeholder engagement and transformational change. Her other professional interests are socio-economic inclusion, cross-sector partnerships and regeneration. She has held a number of non-executive roles, including within the housing sector at Optima-Family, WM Group and Wrekin Housing Trust. Danielle was appointed chair of Walsall Housing Group in February 2019.

Alongside her continued interest in housing, Danielle has held non-executive roles in the NHS. She is chair of Healthwatch Birmingham and of Audit for Healthwatch England. She has previously held non-executive/chair roles at Dudley Primary Care Trust and Dudley and Walsall Mental Health Trust. In 2016, she was asked to become the chair at Walsall Healthcare NHS Trust. Danielle holds an MA in Equal Opportunities from Birmingham City University and a BA in Humanities from University of Greenwich.

Board Attendances in 2020 up to date of resignation: 4/5

Declaration of interests up to date of resignation

- Chair: Healthwatch Birmingham
- Committee Member: Healthwatch England
- Chair: Midlands Landlord
- Co - Chair, Health and Social Care Leadership Centre, University of Birmingham
- Chair: Walsall Healthcare NHS Trust
- Chair: Walsall Housing Group.

Tracy Palmer – Director of Midwifery

Appointed January 2021

Tracy Palmer has been a practising midwife for 33 years and has gained national and international experience in her field. She qualified as a nurse in 1986 and worked as a staff nurse in Emergency Department and Paediatrics at Walsall Healthcare Trust before starting her midwifery training at the Sister Dora College of Midwifery in Walsall.

Having joined the Trust in 2004 as the Clinical Lead Midwife for Delivery Suite and Intrapartum Services, Tracy has held several senior leadership positions within Maternity and Neonates, including Matron for Obstetrics and Gynaecology, Deputy Head of Midwifery, Head of Nursing and Midwifery and finally Director of Midwifery.

Tracy has led on many successful service developments, including introducing and implementing a midwifery-led service at the Trust, maternity triage and induction of labour units. As part of her role, Tracy leads on the national transformational programmes of work for midwifery services for the organisation. As one of the first midwives in the country to acquire Neonatal Life Support Instructor status with the Resuscitation Council UK, she has relished the opportunity to teach in a number of hospitals across the UK and internationally as part of a faculty to teach on the first Asian Neonatal Life Support Provider Course.

Board Attendances in 2020-2021: 1/2

Declaration of interests

- None declared for 2020/2021.

Sue Rawlings - Non-Executive Director

Appointed July 2013 (Served as an Associate Non-executive Director from October 2012)

Mrs Rawlings is a Chartered Certified Accountant who has worked in the public, private and voluntary sector. For the past 20 years, until 2020, she was a partner of the consultancy firm RHCS, a well- established, highly skilled consultancy firm working with a range of cross sector clients from the voluntary/ community / charitable and public sectors. Sue has extensive experience in evaluating the effectiveness of public expenditure and has worked, for example, with the British Red Cross in various parts of the country, conducting needs assessments, developing performance monitoring and carrying out evaluations.

She worked with voluntary and community sector organisations to develop their business planning, their future sustainability and identify their impact. Previously a local improvement advisor appointed via IDeA to the Regional Improvement Efficiency Partnership in the West Midlands, she was, until recently, a Trustee of both the Beacon Centre for the Blind and a Director of Beacon4Life CIC and is now a trustee for Stay – a supported housing charity based in Telford.

Board Attendances in 2020-2021: 10/10

Declaration of interests

- Rawlings Heffernan Consultancy Services Ltd (RHCS Ltd) - Director / Company Secretary ceased 31/07/20
- Trustee and Company Director of Telford Christian Council Supported Housing – STAY commenced 23/02/21
- Board member of Healthwatch Telford and Wrekin commenced 11/05/20 ceased 1/08/20
- Trustee of Beacon Centre of the Blind ceased 01/03/20.

Professor Louise Toner - Associate Non-Executive

Appointed 1 October 2019

Professor Louise Toner is a nurse, midwife and academic by professional background; she has a wealth of experience working with the NHS in England, Scotland, Wales and Northern Ireland and within the higher education sector again across all countries, bar Northern Ireland. Since moving into higher education, she has maintained strong partnership working with colleagues within health and social care across all sectors; she is a member of the UK Universities Council of Deans.

In her current role Louise has responsibility for the faculty's academic portfolio ensuring it is the right offering to meet the workforce needs of employers and the personal and professional development needs of qualified health and social care professionals. She represents the university on the Birmingham and Solihull Local Workforce Action Board and she is a member of their Education Partnerships Sub Group established to enable universities, NHS Trusts and other healthcare providers to work together to recruit and retain students to facilitate sufficient qualified staff entering the workforce. In addition, she is a member of the British Commonwealth Association (BCA), chairing their Education Sub Group and representing the BCA on the Greater Commonwealth Chamber of Commerce in Birmingham/West Midlands.

Louise has also worked for a hugely successful charity in the UK – Macmillan Cancer Support where she was responsible for an Education Development Programme for specialist nurses in Cancer and Palliative Care. She was previously Chair but is now Trustee of the Wound Care Alliance UK a charitable organisation who provide education and training for non-specialist healthcare staff both qualified and unqualified in the field of Tissue Viability. As a surgical ward sister in practice Louise has a special interest in cancer care – the subject of her Master's degree awarded by the University of Glasgow. Her interest in wound care led to her establishing the faculty's Wound Healing Practice Development Unit of which she is the Director. This Unit delivers specialist workshops by our Professors in Wound Healing, undertaking product evaluations often in association with product manufacturers.

Louise's remit within the faculty includes leading overseas activities as a result of which she has been privileged to visit a number of countries meeting with government officials, leading academics and professionals. Along with other colleagues, she is in the process of securing funds to assist developing countries in terms of their healthcare education needs that include caring for older people, primary care, stoma care and wound care. Louise says she feels privileged to be associated with such an innovative and forward-thinking trust, keen to embrace the ways in which academia, research and clinical practice can all work together to improve the care of our patients and provide development opportunities for our staff.

Board Attendances in 2020-2021: 10/10

Declaration of interests

- Associate Dean Faculty of Health, Education and Life Sciences at Birmingham City University
- Member Birmingham and Solihull Local Workforce Action Board and Education Reform Workforce Group
- Member Greater Birmingham Chamber of Commerce Commonwealth Group
- Chair Birmingham Commonwealth Association - Education Focus Group
- Visiting Professor/Advisory Board Member - Lovely Professional University India
- Higher Education Academy - Teaching Fellow
- Member of The Royal College of Nursing UK.

Professor Anand Pandyan - Associate Non-Executive Director

Appointed 1 November 2019

Professor Pandyan is the Professor of Rehabilitation Technology at Keele University and a founder member of The Central England Rehabilitation Network (CEReN). He was previously the Head of the School of Allied Health Profession (at Keele University) with substantial experience in curriculum development and implementation. He has led the transformation of a single programme School into a multi-programme School of Allied Health Professions (doubling the number of students being trained for the NHS) with a substantial research portfolio that will contribute to the 2025 REF submission.

Prior to this he was responsible for developing both developing the Neurological Rehabilitation Research at Keele and developing local research network between the School and the NHS. His personal research aims to: Develop optimal rehabilitation programmes (in particular for people with severe levels of disability) and exercise programmes to maintain health and wellbeing; Measuring patient ability and then modelling the relationship between ability and patient outcomes; and Injury prevention in elite athletes and improving well-being in a working population by drawing on the knowledge we have gained from our research in people with disabilities.

Prof Pandyan has attracted research income in excess of £4 million and authored more than 50 major academic journal articles. Anand has presented his research findings at more than 100 national and international conferences and is a highly regarded and engaging keynote speaker. He advises international and national grant awarding bodies and is an expert consultant to several pharmaceutical companies. He has experience of managing franchise activities and partnership development with both academia and industry.

Board Attendances in 2020-2021: 9/10

Declaration of interests

- Provided consultancy or received honorarium for Allergan
- Provided consultancy or received honorarium for Ipsen
- Provided consultancy or received honorarium for Merz
- Provided consultancy or received honorarium for Digitimer
- Provided consultancy or received honorarium for Biometrics Limited
- Obtained unrestricted educational support from Allergan
- Obtained unrestricted educational support from Merz
- Obtained unrestricted educational support from Biometrics Limited
- Professor of Rehabilitation – University of Keele
- Visiting Professor – Staffordshire University commenced 01/07/20
- Had a PhD student working with University Hospital South Manchester and OpCare-University Hospital South Manchester and OpCare
- Received a research grant from the Stoke Association on Medcity to work with Vitrue to develop and App/system to monitor exercise performance and compliance with the Community.
- Developing a research project with a company called Aparito on an App Development for monitoring stroke patients in the community

John Dunn - Non-Executive Director

Appointed 2 February 2021

John's professional life was spent almost exclusively in the Telecoms sector and he has extensive experience in the field of operations, and customer service. His career includes 20 years' experience at divisional board level in a variety of executive and non-executive roles and his last position with BT was as Managing Director (MD) Openreach. As MD, he was responsible for the delivery and repair of customer service and for the provision and maintenance of the local access network for the south of the UK. Away from the boardroom, John is a keen walker and cyclist and enjoys nothing better than hill walking with his red setter.

Board Attendances in 2020-2021: 2/2

Declaration of interests

- Non-executive Director, Walsall Healthcare NHS Trust

Statement on disclosure to the auditors

Each Executive Director has given a formal statement to the effect that s/he knows of no information which would be relevant to the auditors for the purpose of their audit report and of which the auditors are not aware and has taken all the steps which s/he ought to have taken to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Statement of Accountable Officer's responsibility

The Chief Executive of NHS Improvement has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum, , issued by the Chief Executive of NHS Improvement. 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 purpose 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 with the approval of the Treasury to give a tru.e 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.

I confirm that the Annual Report and Accounts are as a whole fair, balanced and understandable. I take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

Finally, I confirm that as far as I am aware, there is no relevant audit information of which the Trust 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 the Trust's auditors are aware of that information.

Signature:

Prof. David Loughton CBE, Chief Executive

Date: 9 June 2021

Signature:

Kevin Stringer, Chief Finance Officer

Date: 9 June 2021

Governance statement 2020-2021
Organisational code: RL4

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.

Partnership

I acknowledge that I must discharge my duty of partnership, and have undertaken this in a number of ways. During this year the majority of the contacts and meetings described in this statement and the Trust Annual Report have taken place virtually, using video and voice conferencing due to the restrictions placed on us all by the pandemic. Despite this, good contact and relationships have been maintained, fostered and enhanced throughout the year.

As Chief Executive, I attend the Wolverhampton City Council Overview and Health Scrutiny Panel where a range of topics have been discussed with local authority elected members. Reflecting our footprint in Staffordshire, I have also engaged with Overview and Scrutiny Panels and Healthwatch within the County of Staffordshire.

During the year a proportion of my time, and that of Director colleagues, has included continued involvement in the development of Sustainability and Transformation Plans (STP) in both the Black Country and Staffordshire.

There has continued to be close contact with commissioning organisations, and members of my Executive Team and I have attended meetings with Wolverhampton Healthwatch, and the Wolverhampton Health and Wellbeing Board.

Close links have been maintained with NHS England and NHS Improvement (NHSI) through a range of group, individual, formal and informal meetings. I have continued to participate in the meetings of West Midland NHS Provider Trust Chief Executives meetings. All my Executive Directors are fully engaged in the relevant networks, including finance, nursing, medical, operations and human resources.

I am supported in my engagement with partner organisations by the Chairman of the Board, who this year has met with his counterparts at The Dudley Group NHS Foundation Trust, Walsall Healthcare NHS Trust, University Hospital of Birmingham/ Heart of England NHS Foundation Trusts, Sandwell and West Birmingham Hospital NHS Trust, The Shrewsbury and Telford Hospital NHS Trust, the University Hospital of North Midlands NHS Trust, Black Country Partnership NHS Foundation Trust, West Midlands Ambulance Service NHS Foundation Trust, as well as regular meetings with local authority members and officers, and other key players in the city's business and third sector communities. He too has taken part in discussions towards further developing the sustainability and transformation plans (STPs).

I have met periodically with the local Members of Parliament and senior members of the national NHS team present and past.

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance with relevant principles of the Code is considered to be good practice. This Governance Statement is intended to demonstrate how the Trust had regard to the principles set out in the Code considered appropriate for the Trust for the financial year ended 31 March 2021.

Black Country and West Birmingham Healthier Futures Partnership (previously STP) Annual Report Statement from the Independent Chair

Serving a population of around 1.5 million people, our partnership is the collaboration across local authorities, NHS bodies and the voluntary and community sector to:

a. Improve the health of our population by reducing inequalities in health outcomes and improving the quality of and access to services

b. Attract more people to work in health and care in our region through new ways of working, better career opportunities, support and the ability to balance work and home lives

c. Work together to build a sustainable health system that delivers safe, accessible care and support in the right locations, in order to get the greatest value from the money we spend.

After an unprecedented year, my biggest reflection is of pride in our heath and care workforce, together with gratitude for all those who have gone above and beyond to care for people at their most vulnerable and protect many more from the impact of COVID-19. Through the challenges of the last 12 months the strength, the compassion, commitment and determination of our people has been outstanding. On behalf of our partnership, thank you for all that you have done and continue to do.

As COVID-19 pressures start to ease, NHS organisations will face the new challenge of restoring services. Whilst we need to ensure people are seen for the care they need in as timely a way as possible, we also have to guarantee that our NHS workforce are supported to rest, decompress and recover from a year of unprecedented demands placed upon them physically and emotionally. Our People Board is focusing on the wellbeing support required to ensure help and assistance are provided for those who were there for so many people when they were needed most.

For local government partners the challenge of enabling communities and people to safely go about their daily lives is key. Testing capacity and support for local businesses will play a vital part in this, as will support for people and families who need extra help to manage their new circumstances. This year, more than ever, the voluntary and community sector has played a really important role, helping people to stay connected to communities and building resilience in the darkest of times. The kind spirit of a few has shone through our communities and been a lifeline for many.

Perhaps the greatest example of our partnership working has been our vaccination programme which continues at pace. Operating from over 30 vaccination locations we rapidly moved through the cohorts of eligibility, starting with those most vulnerable. Whilst uptake has been generally high, we have seen some areas of concern. We know the lower uptake in some areas will be due to a number of factors, including confidence in the vaccine, convenience of access and also complacency with regard to whether people feel the need to be vaccinated. We also know that COVID-19 has disproportionately impacted on our Black, Asian and Minority Ethnic communities and that worryingly, the uptake of the vaccine is also much lower amongst these groups.

To respond to these challenges, we are increasing our efforts to get the right information to people and have where necessary changed the mode of vaccine delivery to improve accessibility. Working with Public Health in each place, we have also created a network of community champions, as well as working with community and faith leaders and also trusted community voices, to help deliver the right messages.

Our partnership exists to benefit local people, and through our continued collaboration and working together, I am confident we can deliver truly integrated health and care services of which everyone in the Black Country and West Birmingham can be justifiably proud. I would like to thank all health and care colleagues throughout our system for their commitment, dedication and hard work during the past year and for their help in bringing this ambition closer to being realised.

Jonathan Fellows, Independent Chair

Black Country and West Birmingham Integrated Care System

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 The Royal Wolverhampton 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 The Royal Wolverhampton NHS Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

The governance framework of the organisation

We have a well-established framework for governance to inform the Trust Board of operational and strategic risks as well as to provide assurance on business performance and compliance. The framework sets in place under the Trust Board a high-level committee and management structure for the delivery of assured governance.

Sub Trust Board assurance committees are constituted to ensure the delegated operation of effective risk management systems, processes and outcomes. These committees inform and assure the Trust Board through the functioning and reporting of sub-groups and specialist working groups defined in their terms of reference.

The Trust maintained risk management processes throughout the year although during the 1st and 2nd wave of the COVID-19 pandemic there was some adverse impact on meetings and some routine processes as activity pressures increased and staff were redeployed into needed roles.

Some processes were paused for example action follow up, low level risk update, external visit follow up and audits. Focus was maintained on the escalation of risks from service areas, the update of high-level risks and the monitoring and investigation of COVID-19 and other reported incidents.

In May 20 internal audit of risk management included review of the design and operation of the Trust's Risk Management Assurance Strategy and arrangements, which is underpinned by the Risk Management and Patient Safety Reporting Policy (OP10). The report concluded partial assurance with three medium and two low recommendations which included review of risk recording in line with Trust format and strengthening of local minute taking of risk activity. The recommendations are formed into an action plan that is regularly monitored by the Audit Committee.

Trust Board

The Trust Board has met virtually and monthly as planned (except in September 2020 and January 2021, also as planned). Other than for matters requiring commercial confidence or having sensitive patient identifiable or staff identifiable human resources implications, it has conducted its business in public and as soon as was possible, it has made the virtual public Board meeting available to the press, public and other observers. It has been open to questions posted for the Directors at each meeting with responses provided either in or post-meeting.

A high attendance rate by Directors was recorded during the year. The Chairman's term of office commenced from April 2019 and was renewed before the end of the term. At 31 March 2021 the Board comprised two female and six male Executive Directors (Chief Officers); one from a minority ethnic background; and four female and five male Non- Executive and Associate Non-Executive Directors, two from a minority ethnic background.

At each meeting the Trust Board considered reports on:

- Quality and safety
- Serious incidents
- Operational performance
- Financial issues and performance
- The progress of the Financial Recovery Board
- GP Vertical Integration, Innovation and Research
- Reports and minutes from the Trust Board's standing committees
- Cost improvement programme (financial and qualitative delivery – within the Finance Report)
- Mortality (within the Integrated Quality and Performance Report)
- Development of a potential acute collaborative arrangement
- Development of the Wolverhampton Place, the Black Country and South-West Staffordshire Integrated Care Systems (ICS)

The Trust Board receives a monthly Integrated Quality and Performance Report (IQPR) (including national performance measures and 12-month trends). This report includes workforce data such as staff turnover and appraisal rates, metrics relevant to patient experience (such as medication incidents, infection prevention, friends and family test scores and safety thermometer), and those relating to operational performance (such as targets for referral to treatment times, time spent in the Emergency Department, ambulance handover times, cancelled operations and cancer waiting times). The indicators within the report are reviewed annually and approved by the Trust Board. This is added to by the Report of the Chief People Officer.

The Trust Board strives to maintain an appropriate balance between strategic matters and supervising the management of the Trust. Among the former in 2020-2021 were:

- The operational impact and strategic potential impact of the COVID-19 pandemic
- The medium to long term implications of the COVID-19 pandemic, recovery and restoration on the services and staff of the Trust
- The support of the senior team operationally managing the pandemic impact and the support for schemes and investment required as part of the Trust response to the pandemic
- The support for and recognition of closer working relationships with a wide range of stakeholders and partner organisations as part of the pandemic response including the City of Wolverhampton local authority and colleagues in the local Public Health team, commissioners and provider partners
- The continued focus on recruitment of key staff particularly doctors and nurses,
- The continued development of innovation programmes and exploration of the use of artificial intelligence, data and technology in improving healthcare,

- The pause and continuation of the development of a clinical quality improvement programme,
- The five year capital programme revisions and agile responses to changing capital expenditure priorities,
- The continued development of the University of Wolverhampton Postgraduate Academic Institute of Medicine and partnerships with a range of other academic institutions
- The extension of the Trust's own clinical fellowship programme,
- The continued vertical integration of GP practices and development of the Primary Care Networks and Wolverhampton Place,
- The development of an accountable care organisation,
- The contributions to the development of the sustainability and transformation plans, and the ongoing financial challenges within the NHS.

The Trust Board has continued to build on strong relations with stakeholders, including local commissioners, Healthwatch, Public Health and local authority overview and scrutiny committees.

The Non-Executive Directors (NED) are committed to self-development and learning, as evidenced by virtual attendance at events arranged by NHS Improvement (NHSI), NHS Providers, Healthcare Financial Management Associate (HFMA) NED forum, Chair and NED events put on by the Health Services Management Centre, the Good Governance Institute and networking via private firms (particularly legal firms specialising in healthcare law).

Table 13 – Board composition and commitment / experience

Board governance

- All voting positions substantively filled with considerable experience and continuity of Board members
- Senior Independent Director in position
- Clarity over who is entitled to vote at Trust Board meetings
- At least half of the voting Board of Directors comprises Non-Executive Directors who are independent
- Appropriate blend of NEDs from the public, private and voluntary sectors
- Four NEDs have clinical healthcare experience
- Appropriate balance between Directors who are new to the Trust Board and those who have served for longer
- Majority of the Trust Board are experienced board members
- Chairman has had previous non-executive director experience
- Membership and terms of reference of Trust Board committees reviewed during the year
- Two members of the Audit Committee have recent and relevant financial experience
- Trust Board members have a good attendance record at all formal board and committee meetings, and at other board events
- A positive result from the independent external review of governance reported in year.

As well as meeting formally, the whole Trust Board meets every month for a development session, this programme has covered a mixture of informal presentations around strategic and operational matters, as well as informal briefings and discussions, such as on financial pressures and service development opportunities in the Black Country. The NEDs also have a programme of executive briefings from Chief Officers and senior staff on a variety of matters and from the Chief Executive at least monthly in addition to Board, Board Committee and development sessions.

Throughout the COVID-19 pandemic, the Board and Board Committee's, development sessions and briefings have continued as planned using virtual video conferencing and the shared papers system already in place. On occasion, the length and business have been reduced appropriate to operational pressures and meeting requirements. Information and consultation have also been carried out by email where required and appropriate.

Audit Committee

Members: R Dunshea, M Martin and R Edwards

The aims of the committee are to provide the Trust Board with an independent and objective review of its financial systems, financial information, risk management and compliance with laws, guidance, and regulations governing the NHS.

Each meeting received an update on any new risks or assurance concerns from the chairs of the Quality Governance Assurance Committee (QGAC), the Finance and Performance Committee (F&PC) and the Trust Management Committee (TMC). One joint meeting was held with QGAC.

The committee received and discussed reports on the:

- Annual Report for Trust Charitable Funds 2020-2021
- Trust Annual Report and accounts 2020-2021
- Board Assurance Framework, Strategic Risk Register and related governance processes
- Data security and protection
- Management of sepsis recording
- Radiotherapy case investigation
- Human Tissue Authority procedure compliance
- Consultant Job Planning

Most of the audits and reviews were completed to plan against the constraints caused by the COVID-19 pandemic. Where not completed they were planned for completion early in 2021-22.

These matters featured in the committee's reports to the Trust Board, including a high-level summary of the internal audit reports received at each meeting. The Trust Board have been kept informed of when audit reports showed high or medium risk recommendations requiring management attention, and has been assured that mitigating actions are being taken in accordance with the agreed timeframes.

The committee also receives regular reports from the Local Counter Fraud Specialist. The Trust currently complies fully with the national strategy to combat and reduce NHS fraud, having a zero-tolerance policy on fraud, bribery and corruption. The Trust has a counter fraud plan and strategy in place designed to make all staff aware of what they should do if they suspect fraud.

The committee monitors this strategy and oversees when fraud is suspected and fully investigated. The committee seeks assurance that appropriate action has been taken, which can result in criminal, disciplinary and civil sanctions being applied. There were no significant frauds detected during the year, although some cases reported to the counter fraud team remain on-going.

The Chair of the Quality Governance Assurance Committee (QGAC) is a member of the Audit Committee, which helps to maintain the flow of information between the two committees, particularly on clinical audit matters. Two of the three committee members have recent and relevant financial experience.

Non-Executive Directors' attendances were recorded as being high during the year, and the committee was quorate at each meeting.

Quality Governance Assurance Committee (QGAC)

Members: Chair - R. Edwards, L. Toner, A Pandyan (from November 2020)

Aims and objectives of the committee (from ToR)

The aims of the committee are to provide assurance to the Board of the effective functioning of risk management systems through a reporting framework. The framework reviews care standards and targets, monitors quality and safety performance, identifies risks and escalates as appropriate to the Board.

Committee objectives - During the period QGAC had two primary objectives:

1. That the Trust will have developed during the year metrics which will enable the Board to be assured that it can adequately assess the performance of all the divisions.
2. Mortality:

- To understand the drivers for elevated mortality ratios
- To have a robust improvement plan, including target dates
- To be able to demonstrate that we are providing reliable care.

Metrics have been steadily developed and refined. Mortality, which has been the subject of monthly reports, and has been scrutinised as a BAF Risk (SR 12) has now been removed from the BAF, the SHMI having been within expected levels for a sufficient length of time and the reports showing good progress with the action plan.

During 2021 NEDs have discussed future objectives. Linking in with the Trust's Strategic Objectives, QGAC will be considering for 2021-22 objectives featuring: equality of access to health care and equality of outcome; and returning to normal levels of activity in a clinically sound and equitable way.

Frequency of meetings and main focus

During 2020-2021, the committee met virtually on nine occasions, with one meeting (January 2021) cancelled. During peak COVID-19, meetings were reduced to one hour's duration.

Activity and areas of activity

At each meeting the committee received an update on reports in line with its terms of reference (including items below). It escalated risks and assurances to the Board via the chair's report of each meeting and minutes to the trust Board. The list of reports is managed on an annual plan/cycle of work with upward reporting groups and the committee maintains an issues log to communicate issues for redress and record action taken.

- Board Assurance Framework (BAF) – Monthly
- Trust Risk Register (TRR) – Monthly
- Integrated Quality and Performance Report – Monthly
- Learning from Deaths – Monthly, up to and including January 2021.
- Information Governance Toolkit
- Continuous Quality Improvement Reports – Annual Update and Q1 Report
- National Reporting and Learning Systems Report – 6 monthly
- External Reviews Report – Annually
- CQC Well-led Inspection report and actions
- Clinical Audit – Annually
- Litigation and Inquests – Annually
- Health & Safety – Annually

QGAC also received the Cancer Recovery Plan, monthly, to inform its assessment of the BAF risk assigned to it.

In April 2020 the committee agreed the draft Quality Account for the Trust. In November 2020 QGAC received a verbal report on the Trust Strategy and the development of strategic objectives for 2021/22.

In March 2021 QGAC received a verbal report on the prioritisation of patients on waiting lists and how to reduce these in a fair and clinically justified way and asked that the criteria used be made public in an easy-to-understand way. QGAC was also concerned that those who chose not to go ahead with a procedure might be more vulnerable patients, less able to balance the risk from COVID-19 with the risk of not proceeding, and sought assurance that they did receive sufficient advice, and that an analysis would be carried out to see if such groups disproportionately declined treatment.

QGAC receives reports from the Chairs of the Compliance Oversight Group (COG) and the Quality Standards Improvement Group (QSIG), and the minutes of these meetings, which provide assurance through detailed reviews of compliance and risk. The chairs of QSIG and COG escalate to QGAC issues and assurances they obtain from the groups reporting to them. QSIG and COG normally meet each month, but during peak COVID-19 periods these meetings were suspended. QGAC did not receive their Chairs' reports at the meetings in April, May, January and February.

There are plans to merge COG and QSIG into a single committee which was intended to be completed by autumn 2020. These have been delayed by COVID-19, but should take place during summer 2021.

QGAC raised items to the Board from groups reporting to QSIG and COG concerning the following:

Alerts – Resuscitation Group Report - alert relating to audits of resuscitation trolleys, Medicines Management Group - alert relating to delayed antibiotic treatment for patients with sepsis, assure relating to overall management of medicines during COVID-19, Trust Safeguarding Group.

Advisories – National Laparotomy Audit, Cancer 104-day Harm reviews, Pleural Services Group Report, External Reviews Oversight Report, Learning from Experience Group, Equality, Diversity and Inclusion, Infection Prevention and Control.

Assurances – Quality Review Visits, Serious Untoward Incident Report, Radiation Safety Group, Audit of Duty of Candour Compliance, Organ Donation Group, End of Life (Swan) Group, Falls Prevention Group.

Board Assurance Framework (BAF) and Trust Risk Register (TRR)

The committee monitored BAF risks SR12 - Mortality, SR13 – Cancer and SR14 – COVID-19 recovery. QGAC debated the definition of SR14 and the reformulation of SR13. During the year it was decided that SR12 could be removed from the BAF, as the target level for SHMI had been met and maintained.

The committee monitors the Trust Risk Register and advised or alerted the Board regarding new risks or developments in risks as well as requesting improvements in the articulation of risks and questioning risk ratings and the need for some risks to continue on the TRR. The committee was pleased to discuss drafts of the BAF and TRR Heat Map at its meetings in February and March, with a view to having a summary document which enables the meeting to assess the adequacy and completeness of the articulation of risks on the BAF and TRR as well as providing a useful quick reference for the Board.

Matters of note and assurance

Matters featuring in the committee's reports to the Trust Board, included:

Matters of concern – during the year the Chair's report to the Board included:-

Cancer performance and the impact of COVID-19 (April 20); suspension of harm review process and disruption to service (May); increase number of patients waiting over 104/62 days (June). Reduction in Breast screening, with 5000 patients waiting (October).

Suspension impact on elective operations from 11 January 21 due to COVID-19 pressures in order to secure enough staff for the required 200% increase in ICU beds (January 21). Drop in Breast Cancer referrals 2 week wait performance (19.74% in November, 6.25% in December) (January).

During COVID-19, the committee noted the use of private sector providers for urgent cases the redeployment of staff from the theatres at Cannock to ICCU, the adverse impact on Cancer metrics with support sought from other Black Country Trusts (February 21). Restoration of pre-COVID-19 clinics and reductions in waiting times, use of fast track clinics in line with normal levels; breast referral numbers the biggest concern with bookings at day 28 and 170 patients waiting over 14 days. Additional sessions working through the backlog of patients and additional support from one other Trust (March 21).

Other COVID-19 impacts – flow through Emergency Department resulting in long waits and delayed ambulance handovers due to need to keep patients segregated (November 20) with 364 urgent care ambulance handover breaches over 60 minutes in December. Additional measures in place to address off-loading issues and required safety measures concentrating on flow and routing patients to the right ward to reflect their COVID-19 status (January 21).

COVID-19 impact on waiting lists: patients waiting for over 52 weeks for treatment were 10 in April (May 2020), 842 (November), 997 (December), 1443 (January 21) and 2054 in February (March 21).

COVID-19 impact on referral to treatment – The number of patients waiting over 18 weeks deteriorated during February reaching 42,235 (target is below 40,000) due to the impact of COVID-19 related suspension of routine elective inpatients and outpatient clinics. (March 21)

Other COVID-19 and related matters – Medicines: storage, prescribing and use – deep and detailed review carried out in response to issues raised by CQC visit revealed significant issues with a comprehensive action plan (July 20). Shortage of reagents for COVID-19 testing (September 20) escalated nationally. Mental Capacity Act and Deprivation of Liberty Safeguards Assessments: examples of MCA testing not implemented or documented and of omissions/absence of DoLS in some areas with actions to address (October 20). C-Section Rates: emergency C sections at 28% were higher than expected with a combined emergency and elective rate just under 40%.

Proportionately more women required intervention and subsequent C-section including those in premature labour and those seriously ill with COVID-19 (February 21). C sections reduced to 34% by March 21 as COVID-19 levels declined.

Stroke assessment within 24 hours percentage below target due to stroke patients being dispersed to other wards due to COVID-19 with assurances that patients continued to receive appropriate treatment within the 24-hour window. (February 21).

Black Country Pathology Service:

Microbiology at Wolverhampton UKAS accreditation suspended following a virtual inspection with some significant issues including slippage of the audit plan. The assessment report received and action plans in place with review expected in May 21. The Board accepted the recommendation that the highlighted cultural and quality issues be covered in greater depth at a board development session. (March 21)

Clinical Audit: Audit activity was suspended across the Trust for Q1 and 2 2020/21 due to the COVID-19 pandemic and again in January 2021 to end of 2020/21. On 16 March 2020 NHSE confirmed that national audits and some national registries were also suspended with expected reduced levels of completion: 56% in Division 1, 37% Division 2, 35% Division 3. (March 21)

Never events:

Unintentional connection of a patient requiring oxygen to an air flowmeter. Actions included reminder to all matrons of the three barriers that reduce the risk of oxygen tubing being connected to air flow meters and immediate review to ensure air flow meters are not in-situ unless explicitly required. (March 21)

Matters of assurance

During the year the Chair's report included the following -

Mortality: the Learning from Deaths Report and the Mortality Action Plan showed a wealth of actions being taken to improve care and the Trust's understanding of care pathways. This and the steadily reducing SHMI resulted in the Mortality BAF risk SR12 being removed (July 20).

Evidence of learning from deaths through sharing of knowledge gained through SJRs (October)

Information Governance: Trust submission that all conditions were met (September)

Audit of Duty of Candour showed very good levels of compliance in all divisions.

CQI Report showed work had continued including online training materials, development of Outpatient Futures, the Huddle Tool, and a single referral form in Community - staff's own initiative supported by the CQI team. (October)

Discharges: QGAC heard that excellent co-operation between the Trust and Wolverhampton Social Services had enabled patients to be discharged swiftly and safely, maintaining flow out of the hospital and freeing up beds. (March)

Matters of achievement

During the year the Chair's report included the following:

Quality Review Visits to South East District Nurses based at Bilston Health Centre – two domain good and three outstanding - and to Durnall Unit, September 2019 – all domains good, with Caring outstanding, and all actions implemented.

COG: Patient Experience Report: There has been considerable and increased volunteering activity, the Trust's success being reported on the national news relating to the recruitment of Community Clinical Volunteers.

Organ Donation: Despite all the difficulties of COVID-19, RWT's performance has been good, and from being in the bottom tier (tier 4) for performance in 2016 the trust is now in line to be in the top tier. (November)

Committee non-executive members

QGAC exchanges information with other committees, for example agreeing to take on the follow-up of one of the Internal Audit reports (Radiography in the Radiotherapy Department) and passing on one issue concerning digital innovation to the Innovation Committee. The Chair of the QGAC attends the Audit Committee, which helps to maintain the flow of information between the committees, particularly on clinical audit matters.

Audit was informed of the self-assessment QGAC carried out (see below) covering, in particular, QGAC's role in monitoring clinical audit. The Healthcare Quality Improvement Partnership's publication Clinical Audit: a simple guide for NHS boards was used to review how clinical audit is managed, and the Medical Director will be considering with other stakeholders the way clinical audit can be redesigned to align more closely to the Trust's strategic objectives. A paper on this should come to QGAC in May 2021. One QGAC member is also on the Innovation Committee which assists the flow of information on digital health matters.

Self-assessment: QGAC members completed a self-assessment questionnaire based on an adaptation of a standard Audit Committee format. The results were provided to the September meeting. QGAC reviewed its TOR in April 2020 and March 2021 and received board approval. Deloittes observed the February 2021 meeting and the Company Secretary for Walsall Healthcare NHS Trust the meeting in March 2021.

Finance and Performance Committee

Committee M Martin, Chair, S Rawlings, J Hemans, J Dunn (from February 2021)

The aims of the committee are to provide the Trust Board with assurance on the effective financial and external performance targets of the organisation. It also supports the development, implementation and delivery of the Medium-Term Financial Plan (MTFP) and the efficient use of financial resources in order to review the Trusts' financial strategy, performance and business development

The committee met monthly and considered in detail:

- Trust's financial position
- Financial Recovery Board report which includes progress on the Cost Improvement Programme
- The progress of the capital programme
- Performance aspects of the Trust Board's quality and performance report.

It also considered

- Impact of COVID-19 on Performance
- Cancer Action Plan
- Group, Service Line Reporting
- Sustainability and Transformation Programme (STP)
- Contracting & Business Development Update
- Annual Budget/Income Expenditure Plan

- Cash Flow Report
- Temporary Staffing Dashboard
- Local Clinical Research Network (LCRN) finance report
- Procurement report
- 5 Year Capital Plan
- Backlog Maintenance Programme
- Other matters associated with operational finance and budgeting.

The non-exhaustive list is managed on an annual plan/cycle of work with upward reporting groups and the committee maintains an issues log to communicate issues for redress.

Matters of note and assurance

These matters featured in the committee's reports to the Trust Board, including;

Matters of concern - During the year the committee has noted the following matters of concern:

1. The potential impact of COVID-19 on the Trust's financial position and on performance
2. The recovery plan for restoring services especially for cancer referrals
3. The agreement of the capital budget including COVID-19 related capital was not finalized until late in the financial year. The Trust achieved its CRL.

Matters of assurance - During the year the committee has noted the following matters of assurance:

1. The cashflow management was considerably helped by the payments in advance and healthy cash balances were maintained
2. The EU transition meetings monitored the preparedness for leaving the EU and procurement did extensive work to secure the supply chains
3. The full budget planning exercise was undertaken across the Trust for expenditure in 2021/22.

Matters of achievement - During the year the committee has noted the following matters of achievement:

1. The continued high performance of the Clinical Research Network West Midlands. All non-essential clinical trials were paused and focus was on urgent public health COVID-19 studies.
2. The Babylon contract was reviewed in detail and recommended to the Board for approval

Committee Non-executive Members

The Chair of the Committee is a member of the Audit Committee, which helps to maintain the flow of information between the committees, particularly on financial risks.

Non-Executive Directors' attendances were recorded as being high during the year, and the Committee was quorate at each meeting.

Workforce and organisational development (WOD) committee

Members: Chair: J Hemans, Members: R Dunshea + one 'floating' Member

Aims of the committee

- The purpose of the committee is to provide the Board with assurance that:
- The organisational development and workforce strategy, structures, systems and processes are in place and functioning to support employees in the provision and delivery of high quality, safe patient care
- Processes are in place to support optimum employee, engagement, wellbeing and performance to enable the delivery of strategy and business plans in line with the trust's values
- The Trust is meeting its legal and regulatory duties in relation to its employees
- Where there are human resource risks and issues that may jeopardise the Trusts ability to deliver its objectives, that these are being managed in a controlled way through the Trust Management Committee.
- The organisational culture is diagnosed and understood and actions are in place to ensure continuous improvements in culture.

To provide assurance on the following key areas of workforce governance:

- Resourcing and Skills
- Leadership & organisational effectiveness
- Engagement & Culture
- Wellbeing
- Productivity

Frequency of meetings and main focus

During 2020-2021, the committee met six times (bi-monthly).

At each meeting the committee considered progress updates on:

- Executive Workforce Report including update from Model Hospital
- Workforce Resourcing & Productivity (including Retention)
- Employee Relations and Improving People Practices Update
- Staff Engagement and Surveys and Communications Agenda
- Education & Training and Apprenticeships & Leadership
- Equalities, Diversity & Inclusion
- Workforce Plan
- Health & Wellbeing
- Board Assurance Framework
- Divisional Deep Dive Reviews.

Activity

The committee received and discussed reports on:

- Executive Workforce Report
- Targets for 2020-2021
- Health and Wellbeing Support for Staff – During and Post COVID-19 Surge periods
- Board Assurance Framework
- Discussion on Anti-Discrimination
- Workforce Resourcing & Productivity (including retention)
- Employee Relations and Improving People Practices
- Education & Training, Apprenticeships and Leadership
- Equalities: WRES and WDES Data
- Division 1, 2 & 3 Deep Dive/Reviews
- Institute of Healthcare Management
- RWT Response to the National People Plan
- Equality, Diversity and Inclusion: BAME Update Report
- Staff Engagement & Survey and the Wider Communications Agenda
- Update on Job Planning Committee
- Reverse Mentoring
- Workforce Modelling and Planning
- Recruitment - Analysis Update Report
- Key Update - Staff Vaccination
- Review of Annual Planner 2021-2022 and Terms of Reference
- Workforce & Organisational Development Strategic Objectives (2021/22)
- Black Internship Programme

- Equality, Diversity & Inclusion Update
- Nurse Staffing During COVID Response
- Wellbeing Guardian
- Race Code
- 2020 Workforce Race Equality Standard (WRES) Report
- Risks Review / Assessment re Revised Strategic Objectives and Aims.

The non-exhaustive list is managed on an annual plan/cycle of work with upward reporting groups and the committee maintains an issues log to communicate issues for redress.

The committee also received regular reports from the Operational Workforce Group (OWG).

Matters of note and assurance

Matters of concern –

During the year the committee has noted the following matters of concern:

1. Job Planning – need to have a full and regular update on the plans and progress on its implementation
2. Employee Voice Groups – offer to expand opportunity to include NEDs

Matters of assurance –

During the year the committee has noted the following matters of assurance:

1. Recruitment – an understanding of where we recruit from
2. Workforce modelling & planning – need to develop an action plan
3. Equality, Diversity & Inclusion – more detailed plans to be reviewed
4. More extensive review on the wider attraction & retention agenda

Matters of achievement –

During the year the committee has noted the following matters of achievement:

1. Armed Forces Employer Recognition Scheme – Gold Award
2. Implementation of e-job planning, e-leave and medical e-roster
3. Continued reduction in vacancy levels
4. Introduction of reverse/diversity mentoring
5. Black Internship Programme
6. Development of an EDI Delivery Plan
7. Establishment of Employee Voice Groups
8. Development of the Inclusive Recruitment Toolkit
9. Focus on the Wellbeing agenda, both pre and post COVID-19
10. Implementation of MH First Aiders
11. Development of COVID-19 risk assessments
12. Actions in relation to improving people practices
13. Review and implementation of workforce thresholds and targets
14. Establishment of the West Midlands Hub of the Institute Healthcare Management

Committee non-executive members

The Chair of the Committee is a member of the Finance & Performance, Remuneration and Clinical Ethics Committees, which helps to maintain the flow of information between the committees, particularly on finance and clinical audit matters.

The committee members (NEDs) have experience across, Audit Committee, Finance & Performance, Charity and Quality Governance Assurance Committees, that they bring to bear on the matter attended to at the committee.

Non-Executive Directors' attendances were recorded as being high during the year, and the committee was quorate at each meeting.

Remuneration Committee

Members: M Martin (Chair), S Field, R Edwards, J Hemans, S Rawlings

The purpose of this committee is to advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors. The Remuneration Committee met several times during the year as required and has reviewed Executive Director Remuneration and appraised the performance of the Chief Executive (in his absence). The Chairman appraised all of the Non-Executive Directors and the Senior Independent Director (SID) appraised the Chairs performance.

Charitable Funds Committee

Members: S Rawlings (Chair), R Dunshea

The aim of the committee is to administer the Trust's Charitable Funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

During 2020/2021, the committee continued to benefit from the dedicated support of an in-house Fundraising Coordinator and the Community and Events Fundraiser.

The Fundraising Team are ably supported by the Head of Communications and her team, as well as the on-going help of the Finance Team and external investment adviser. The refreshed newsletter and increased use of social media has raised further awareness of the charity and our work and enabled us to publicly thank our dedicated supporters for everything they have done to support our work over the last year.

A wide range of projects were supported during the year for the benefit of the welfare and comfort of our patients and staff as well as some capital items – going over and above that which can be provided by the Trust itself.

Trust Management Committee

Aims of the committee

Chaired by the Chief Executive, the Trust Management Committee (TMC) provides a formal platform for the major decision-making process for clinical and non-clinical operations, and as such is not attended by Non-Executive Directors, but all of the Executives attend, along with Divisional Medical Directors and Heads of Service. High attendance rates were recorded at all of these meetings.

Frequency of meetings and main focus

During 2020-2021, the committee met monthly except in August and December

Activity

The committee receives monthly reports from the divisions on governance, nursing and quality issues, as well as business cases above a certain value. The committee also receives monthly updates on finance, human resources, the capital programme, vertical integration, nursing and midwifery professional issues, policies, the Integrated Quality Performance Report (IQPR), and the Trust efficiency programme.

Quarterly updates are presented on cancer services, infection prevention, research and development, information governance and the integrated electronic patient record project. Reports on other matters, such as education and training, are also submitted periodically. During the year, the committee started to include on its agendas a strategic matter for discussion, in order to engage the members in considering and debating together some of the bigger issues facing the organisation going forward.

It approves in line with standing financial instructions, some business cases and all new or significantly changed policies and procedures. The non-exhaustive list is managed on an annual plan/cycle of work with upward reporting groups and the committee maintains an issues log to communicate issues for redress.

Matters of note and assurance

Matters of concern - During the year the committee has noted the following matters of concern:

COVID-19 and the impact on staff health and wellbeing and the local population it serves

Matters of assurance - Restoration and Recovery of Services

Matters of achievement - Becoming a Smoke Free Trust - 1 October 2020

Innovation, Research and Adoption Committee

Members: Professor A Pandyan, R Dunshea (Chair).

The aims of the committee are to provide the Trust Board with an independent and objective review of the Trust's innovation and research aims and developments. This is a new committee and 2020-21 was its first full year of working.

Each meeting received reports from the executive and senior clinical leads on the initiation of strategic innovation development projects. Presentations were received on digital strategy, health informatics systems, artificial intelligence applications, COVID-19 research projects, and the establishment of an integrated care system for Wolverhampton. It also was briefed on the progress to set up the Institute of Health Innovation; a partnership with the University of Wolverhampton.

The committee had oversight of new contractual partnerships with Babylon Health and Sensyne Health. These are at early stage and the focus must now move to benefits realisation. The impact of the COVID-19 pandemic has been profound and has in many ways acted as a catalyst to improve services through the use of IT and related technologies. The committee was keen to ensure lessons have been learnt and long-term transformation achieved to improve patient outcomes.

The committee met five times during the year and was quorate. The contributions from a broad range of clinical and IT disciplines were greatly appreciated.

Clinical Ethics Committee

Members: Prof. L. Toner (Chair), Prof. S. Field, Mr J. Hemans (to March 2021)

The committee was newly formed in June 2020 and comprises a Non-Executive Chair and two NED members including the Trust Chair and a range of clinical professional staff from across the clinical professions and service areas. It has met on average every other month since with hiatus during COVID-19 waves due to clinical operational pressures.

The committee has used the Oxford Ethox Clinical Ethics Committee materials and training information from its formation and early development. To date it has considered set case examples and one clinical example following the resolution of the case. It will continue its development in 2021 and 2022 with input from clinical ethics experts and access to external training and development opportunities

Freedom to speak up – concerns raised

The Royal Wolverhampton NHS Trust has been committed to its Freedom to Speak Up (FTSU) journey and the Guardian role since October 2016. The Trust Board have shown their full commitment and support to embed FTSU within the organisation as per national policy and requirements.

The Trust has been working with the FTSU Guardian to progress the below five identified FTSU objectives and has devised a Speak Up Vision. The objectives below have been successfully achieved and are evidenced in the FTSU Guardian Board reports.

Our objectives are;

1. Raise the profile and develop a culture where speaking up becomes normal practice to address concerns
2. Develop mechanisms to empower and encourage staff to speak up safely
3. Ensure that the Trust provides a safe environment for employees and others to raise concerns and speak up
4. Ensure that concerns are effectively investigated and the Trust acts on its findings
5. Ensure shared learning amongst local/regional/national Networks

COVID-19 & Speaking Up

Despite the challenges of COVID-19 the Guardian has worked with the organisation to provide the safest way to deliver FTSU support and has also offered support to the Contact Links (volunteer employees supporting FTSU). This year there has been an increase in the number of cases being reported to the Guardian, a good indicator of speaking up culture as evidenced in the most recent

FTSU Trust Board report.

During the last unprecedented year, FTSU has focused on, online awareness training sessions and responded to departmental concerns. Training packages have been devised and delivered combining Equality, Diversity & Inclusion (EDI), Psychological Safety, and safe speaking up environments. This has been well received and has been successful due to the collaborative approach taken with the Trust EDI Lead, HR Advisory, Governance, Divisional, Departmental leads, and the Education & Training department.

FTSU Index Report

The National Guardian's Office (NGO), NHS England and Improvement have published a FTSU Index report since 2018. The report brings together four questions from the NHS Staff Survey that relate to whether staff feel knowledgeable, secure, and encouraged to speak up and whether they would be treated fairly after an incident. The FTSU Index seeks to allow trusts to see how an aspect of their FTSU culture compares with other organisations so learning can be shared, and improvements made (National Guardian Office: 2020).

The RWT FTSU Index Score has seen a positive increase year on year;

2018	77%
2019	78%
2020	78.4%

The 2019 FTSU Index score recorded a midrange position which was slightly lower than average at 78%. In 2020, this position has improved slightly to 78.4% however benchmarking data is currently not available. The Trust is showing improvements to its FTSU culture; further actions to embed FTSU within the organisation are required to ensure RWT achieve an above average FTSU Index score. The Guardian will work closely this next year with key stakeholders of the Trust to support actions in improving the FTSU Index score.

FTSU data

Here is the Trust Freedom to Speak Up data recorded for the Financial year 2020/21 and reported to our Trust Board as well as our national requirement to report this data to the National Guardian Office; an independent non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes business as usual. The office is not a regulator, but is sponsored by the CQC, NHS England and Improvement.

Table 14

Figure 1: Total Number of FTSU cases reported to the National Guardian Office

2020/21	Total number of cases brought to Freedom to Speak Up Guardians, Champions and Ambassadors in your trust	#Cases raised anonymously	# of cases with an element of patient safety/quality	# of cases related to behaviours, including bullying / harassment	# of cases where people indicate that they are suffering detriment as a result of speaking
Q1 2020/21	22	1	4	16	2
Q2 2020/21	35	1	4	28	4
*Q3 2020/21	29	3	5	21	2
Q4 2020/21	27	3	6	20	4

Freedom to Speak Up continues on its successful journey at The Royal Wolverhampton NHS Trust, and the collaborative approach has enabled quality interventions to take effect and improve the experience of staff and keeping our patients safe.

Capacity to handle risk

Risk Assessment

The Trust Board has approved a Risk Management Assurance Strategy which identifies that the Chief Executive has overall responsibility for risk management within the Trust. Within the strategy (and supporting policies) all managers and staff have delegated responsibility identified for the management of risk as part of their core duties. Training is provided to equip staff with appropriate knowledge and skills via a combination of e-training packages and handbook resources. A risk management e-training is available for senior managers and a separate package for all staff.

We manage risk through a series of processes that identifies risks, assesses their potential impact, and implements action to reduce/control that impact.

In practice this means:

- Interrogating internal sources of risk intelligence and activity to inform local and Trust level risk registers and assurance frameworks (e.g. incident, complaint, claim, audit, and compliance)
- Using committee / subgroup reporting to inform the risk registers
- Reviewing external / independent accounts of our performance to inform risk status (e.g. CQC standards, national benchmarks, external reviews and internal audit reports)
- Integrating functions (strategic and operational) at all levels of the Trust to feed a risk register and escalation process
- Using a standardised approach to risk reporting, grading and escalation. Our categorisation matrix supports a standard approach to risk tolerance
- Monitoring controls through positive and negative assurance and treatment actions for each risk, to mitigate and manage residual risks
- Developing and implementing a risk management and patient safety reporting policy (OP10) across the Trust
- Refinement of risk management training made available to all staff (including senior managers)

Management of the risk registers within the Trust

Risk registers are managed at the following levels:

- Divisional/Directorate/Departmental – operational risks that include clinical, business/service, financial, reputational, and patient/staff/stakeholders
- Trust Risk Register (TRR) – Any risks graded as 12 or above are escalated to the TRR for consideration by Directors. This has the purpose to inform Directors and the Trust Board of operational risks which may adversely impact the BAF and strategic objectives. Risks / elements of controls may also be delegated from the BAF to operational risk registers for management
- Board Assurance Framework (BAF) – Contains all risks which impact on our strategic objectives.

Each risk on the BAF and TRR has an identified Director and operations lead to manage the risk.

The TRR and BAF were reviewed by Directors, the Board and management during 20/21at the following frequencies:

- QGAC – Monthly
- Trust Board – Bi Monthly
- Finance & Performance Committee – Monthly
- Delegated Committees – Monthly
- TMC review TRR – Monthly
- Divisional Governance – Monthly

During the year we have maintained focus on the quality of controls assigned to risks at all levels and the principles of measurable controls are applied. For risk registers to remain effective priority is also placed on the completion and update of assurances and actions to manage risk.

A total of 57 risks on the BAF and TRR were managed during the year 2020-2021, of these 21 were new risks identified in year. The 57 risks comprised of the following categories, 14 were red (red being the highest risk rating), 42 were amber, and one was yellow.

There were 20 new risks added onto the TRR in 20/21 including in the following areas (for example): Perfusion staffing, Prescribing & Administration of Critical Care Medicines in COVID-19, Safe and proper use of medicines, Number of registered nurses available who are trained to deliver Systemic Anti-Cancer Treatment (SACT), Looked After Children & Young People in Care, Cytology Pin Register, Room availability within the community setting for community midwives, Laboratory shortage of reagents for COVID-19 testing, Mental Capacity Assessment, Cardiothoracic surgical waiting list.

There was 1 new risk added onto the BAF in 20/21; SR14 - Trust services and reputation are adversely impacted upon by the medium to long term impacts of the COVID-19 outbreak.

There were 34 risks closed as at 31 March 2021, the remaining 23 to be carried forward to 2020/21.

There are two Red Risks on the Board Assurance Framework and three on Trust Risk Register (TRR) relating to Cancer performance metrics and the potentially adverse impact of the COVID-19 outbreak (BAF) and issues relating to review and communication of test results, Network support for Vascular Services and Consultant cover in Cancer Services (TRR).

The risk and control framework

The Board-approved Risk Management Assurance Strategy includes the following:

- The aims and objectives for risk management in the organisation, aligned to our vision
- A description of the committee arrangements and relationships between various corporate committees and subgroups
- The BAF and process for management of risk registers
- The identification of the roles and responsibilities of all staff with regard to risk management, including accountability and reporting structures.
- The promotion of standard risk management systems as an integral part of assurance provision
- A description of the risk management process and a requirement for all risks to be recorded in a risk register prioritised (i.e. graded) and escalated using a standard scoring methodology

We seek to identify risks through all available intelligence sources including independent review, external review and assessment. The risk management process is supported by a number of policies which direct on risk assessment, incident reporting and investigation, mandatory training, health and safety, conflict resolution, violence and aggression, complaints, infection prevention, fire safety, human resources management, consent, manual handling and security. All policies have identified audit, monitoring and training arrangements.

The BAF identifies the risks to our strategic objectives, the key controls in place to manage these risks and the effectiveness of the controls shown in positive and negative assurance. The Internal Audit of the Board Assurance Framework (April 2020) reported significant assurance with 4 low and one improvement recommendation including that BAF reporting should make explicit the relationship between operational and strategic risks.

In addition, during 2020/21 the local (Trust initiated) audit of the Risk Management Strategy and Reporting Policy (OP10) showed good compliance with risk register reviews at all levels and sustained improvement with risk escalation/management.

All Committees of the Trust Board (excluding TMC) are chaired by Non-Executive Directors to reflect the need for independence and objectivity, ensuring that effective governance and controls are in place. This structure facilitates appropriate scrutiny and challenge of the performance of the organisation. The Committees met regularly throughout the year, and reported to the Trust Board following their meetings.

Risk management assurance - The trust annual risk management audit concluded partial assurance with two low and three medium recommendations. The Trust takes a continuous improvement approach to its risk management arrangements and will action the recommendations and opinion of its internal auditors (Grant Thornton) to progress its governance and risk management arrangements. The new divisional structure, now comprising three divisions has a well embedded reporting structure. The review of governance infrastructure and functions for the Trust will reinforce and enhance a future for future governance service.

Risk Management training - A risk management e-training package for senior managers and staff is made available on the Trust intranet site. During the 1st and 2nd wave of COVID-19 compliance follow up of risk management training was paused although remained available for staff that were able to complete the training.

During 2020/21 the Trust sustained improvement in the update of the TRR, aided by the set-up of a new monthly Risk Register Review Meeting. The timeliness of risk escalation to Trust TRR level has been a focus of the group and improvements made in year.

Assurance priorities 2021/22

Review and align Quality assurance frameworks for QRV, Leadership Walkabouts and Quality audits

Implement systems and processes falling from the National Patient Safety Strategy

Embed the revised Quality reporting structure

Undertake an independent Well Led Review at the Trust

Challenges 2021/22

The Trust continues to progress its ambition to become an organisation providing an integrated care system. This will present new challenges as well as opportunities to streamline and evolve primary and secondary care pathways. A priority will also be to reinstate all service activity, reduce the backlog created by the COVID-19 pandemic and return to national target achievement.

As well as developing systems, processes and assurance structure, the trust also intends to demonstrate improvement. The enhancing of working links between Clinical Improvement Team and Governance and Risk Management team is key to this and will be complimented by the introduction of the new Patient Safety Specialist role.

Some of key achievements over the past 12 months are:

The Royal Wolverhampton NHS Trust continues to be rated 'Good' overall by the Care Quality Commission (CQC). During the COVID-19 Pandemic CQC adapted their inspection process to a Transitional Monitoring Approach (TMA), this involved telephone calls with organisations and reviewing a number of KLOE questions (Key Lines of Enquiry).

The Trust was engaged with three CQC TMA type calls relating to Emergency Department (ED), Infection Prevention (IP) and Well-Led. The feedback from CQC for ED and IP were of a good standard and the Trust is awaiting feedback from the Well-Led review.

Over the year various notifications were submitted to CQC relating to temporary closures in Primary Care, Urgent Treatment Centre due to COVID-19 and one change related to temporary appointment of nominated individual due to internal cover arrangements.

The Trust assesses ongoing CQC Compliance via Quality Review Visits (QRV) and lead assessment against the Fundamental standards of care, and self-assessment against Core Service frameworks.

The Trust has been unable to complete a full programme of quality review visits 2020/21 to assess ongoing compliance with Care Quality Commission (CQC) regulations due to the COVID-19 pandemic. Three QRVs have however been undertaken during this period. We are currently reviewing the QRV process going forward. An annual report on the 2020/21 quality review visit programme will be presented in May/June 2021. Further processes undertaken this year include confirm and challenge for key themed areas and CQC action plan monitoring of closed actions.

Compliance summary

The Trust is fully compliant with the self-assessment, declaration and registration requirements of the Care Quality Commission. 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 risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The Trust has recently approved a new 'Green Plan' bringing together all aspects of climate impact management.

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

The Trust has a robust governance structure in place ensuring monitoring and control of the effective and efficient use of the Trust's resources. Financial monitoring, service performance, quality and workforce information is scrutinised at meetings of the Trust Board, F&PC, TMC and at divisional team meetings.

The Trust has achieved all of its statutory financial targets, achieving an end of year surplus of £3.0m, delivering the Capital Programme within its Capital Resource Limit and achieving its External Funding Limit. The Trust has arrangements in place for setting objectives and targets on a strategic and annual basis. These arrangements include ensuring the financial strategy is affordable and scrutiny of cost savings plans to ensure achievement, with regular monitoring of performance against the plans.

This is done through:

- Approval of the annual budget by the Trust Board
- Monthly reporting to the Trust Board on key performance indicators covering finance, activity, governance, quality and performance.

Monthly reporting to the F&PC, Regular reporting at Operational and Divisional meetings on financial performance.

Finance Recovery Board meetings to oversee the Lord Carter economies work streams, and the Cost Improvement Programme.

Internal audit has provided assurance on internal controls, risk management and governance systems to the Audit Committee and to the Trust Board. Where scope for improvement in controls or value for money was identified during their review, appropriate recommendations were made and actions were agreed with management for implementation. The implementation of these actions is monitored by the Audit Committee.

Information governance and data security

Summary of serious incident requiring investigations involving personal data as reported to the Information Commissioner's Office in 2020/21

The table below details the incidents reported on the NHS Digital incident reporting tool and to the Information Commissioners Office (ICO), within the financial year 2020-2021. Any incidents that are still being investigated for the period 2020-21 are not included. The incidents listed below are for the Royal Wolverhampton NHS Trust and GP partnerships that have joined the Trust as listed below.

Table 15

Date incident occurred (Month)	Nature of incident	No. of data subjects	Description/ Nature of data involved	Further action on information risk
November 2020	Disclosed in error - email	10	A member of staff sent out a New Starter form via the recruitment system to at least 10 new starters. Unfortunately, the member of staff did not check the new starter form prior to attaching it to the system and the form was not blank, it contained sensitive personal information about an individual. They are aware that at least three of the recipients have read the email as they received phone calls from these individuals yesterday advising they had received it.	Contacted system provider to break the link in the email so individuals who had not opened the email prior to this could no longer see the email attachment. They also contacted all known recipients and asked to delete the email and situation was contained.
November 2020	Disclosed in error – email	1	Clinical letter for child 'A' was sent with details for child 'B'. Both children were being treated at the same clinic however information disclosed included the wrong diagnosis for child A.	Correct letters were sent to the relevant children's GPs/Children Hospital Consultants and advised to ignore the previous letter and confidentially destroy. Change in process with medical secretaries was implemented to ensure adequate checks are done on letters before being sent to patients and an audit was requested to ensure all letters sent around the same time were correct.
December 2020	Lost or Stolen Paperwork	40+	A member of staff who was planning on working from home, took blood request/ referral forms home so they could book clinic appointments for the referrals. On their way home, their car was stolen with belongings, the blood request forms were among their belongings in the car. Blood forms contained name, address, sex, DOB, NHS Number and were all for glucose tolerance tests.	Car and its contents were not recovered. All patients were identified and were rebooked in for appointments so no delay on clinical care.

Table 16 – Incidents classified at lower severity level

Incidents classified at severity level 1 are aggregated and provided in table below:

Summary of other personal data related incidents in 2012-21		
Category	**Breach Type**	**Total**
A	Corruption or inability to recover electronic data	2
B	Disclosed in error	85
C	Lost in transit	3
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	7
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	3
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	5
J	Unauthorised access / disclosure	8
		113

Data protection and security toolkit return 2019/ 2020 – final submission

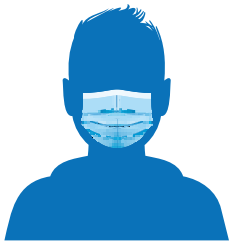
Due to the current situation relating to COVID-19, NHS Digital (NHSD) recognises that it will be difficult for many organisations to fully complete the toolkit without impacting on their COVID-19 response. NHSD took the decision to push back the 2019/20 deadline for DSPT submission to 30 September 2020. The results for the final submission for 2019-20 for all are shown below.

The Royal Wolverhampton NHS Trust	**RL4 Standards Met**
Alfred Squire Road	M92002 Standards Met
West Park Surgery	M92042 Standards Met
Thornley Street	M92028 Standards Met
Lea Road	M92007 Standards Met
Penn Manor	M92011 Standards Met
Coalway Road	M92006 Standards Met
Warstones	M92044 Standards Met
Lakeside	M83132 Standards Met
Dr Bilas Surgery	M92026 Standards Met

Personal data incidents 2020/21

Summary of serious incidents requiring investigation involving personal data as reported to the Information Commissioner's office in 2020/21. This information can be found in the Governance Statement.

Looking forward to 2020/21: Data security and protection (DSP)



Due to the current COVID-19 response the DSP Toolkit (DSPT) for 2020-21 will not be submitted until June 2021, in line with the newly set date by NHS Digital. The Trust will continue to work towards achieving compliance with the DSPT which will be published later this year. An internal audit of the DSPT in November 2020 had provided significant assurance of the processes and evidence that is in place to support the DSPT submission.

The Trust continues to monitor patterns and trends of data security incidents and implementing measures to reduce these to the lowest level practicable. Current risks include the increasing risk of external threats in relation to Cyber security, such as particularly email 'phishing'. Other risks to data security include - disclosure in error due to increased remote working during the COVID period.

Work continues to improve controls and practices to manage these risks. The Trust has continued to embed the requirements of the General Data Protection Regulation 2016 (GDPR) into day to day practices, monitored via a variety of groups. This is to ensure that data privacy is at the forefront of the care that we provide and the information that is captured.

The Trust remains focused on embedding principles of privacy by design into Trust processes, from procurement to digital innovation and service redesign. This program of work is monitored though the committee structure.

- The Trust has several committees dedicated to reviewing assurance in relation to DSPT and GDPR, chaired by senior Board members
- The Chief Medical Officer is the Trust's trained Caldicott guardian, and is responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. The Guardian plays a key role in ensuring that Trust satisfies the highest practical standards for handling patient identifiable information, and Chairs the Information Governance (IG) Steering group and GDPR implementation group
- The Chief Financial Officer is the Trust's Senior Information Risk Officer (SIRO) and is responsible for monitoring the Trust's overall information risk, ensuring we have a robust incident reporting process for information risks. The SIRO reports to the Trust Board and provides advice on the matter of information risk. The SIRO is also a member of the IG Steering Group and co-chair of the GDPR implementation group
- The Trust has an assigned Data Protection Officer (DPO) who acts independently to ensure compliance with the GDPR as well as monitoring its application across the Trust. The DPO has a reporting line into the Caldicott Guardian through to the Trust board
- The Trust is in the process of implementation a robust asset management system and defining establishing clear responsibilities for Information Asset Owners (IAO) across the Trust to facilitate robust and timely escalation of information risk escalation to the SIRO
- Regular reports are provided to the Trust Board during the year to ensure that they are sighted on and support the Trust's plans in relation to data security and protection. To support this each toolkit assertion is aligned to a director responsible on the board
- All Trust board members received NHSD approved cyber and data security training, and will receive updates and briefings in relation to the Trust performance in this area.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

Guidance for Quality Accounts remains in place nationally, which outlines the requirements with respect of the format, content and reporting arrangements for the annual Quality Accounts. The Trust used this guidance to ensure that its requirements were included in the Trust's Quality Account 2020-2021.

The Trust's quality priorities for 2020-2021 were selected as part of a consultation process with our staff and external stakeholders. In addition, the Trust reviewed what patients and members of the public said about us through national and local surveys, in-patient feedback received through complaints, compliments and the Friends and Family Test. In addition, various national and local guidance and feedback from the Care Quality Commission were considered.

The Quality Account outlines the progress made against the 2020-2021 objectives together with details of the key objectives for the forthcoming year. These objectives have been set based on the priorities of the Trust, considering external accreditation, variety of surveys, CQC inspection outcomes, key improvement priorities and views of the staff, patients, public and our key stakeholders.

The following information has been included in the Quality Account as per the 2020-2021 requirement outlined in the letter received by NHS England and Improvement in January 2020:

- A statement regarding progress in implementing the priority clinical standards for seven-day hospital services
- In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS trusts and NHS foundation trusts in England to report annually on staff who speak up (including whistle-blowers). Ahead of such legislation, NHS trusts and NHS foundation trusts are asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment. This disclosure should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the Trust
- Organisations have also been reminded that schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires "a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the Trust's Quality Account"
- Despite the assurance audit being ceased for the 2019/20 Quality Account, updates against the actions agreed following the last year's audit have been provided
- The draft Quality Account shared internally contains information relating to the National Inpatient Survey results for 2020. However, these results are currently embargoed and as such cannot be shared externally
- Final data is awaited for a number of data sets, which will be included in the final version of the Quality Account.

Note:

The Quality Account was to be published by no later than 30 June 2020 and as a result, the final version presented to Trust Board on 2 June 2020. However, please note the caveat with regards to the National Inpatient Survey 2019. In addition, NHS England and Improvement have indicated that due to the significant pressures associated with COVID-19 (coronavirus) pandemic, the publication date has been deferred to later in the year. However, RWT has kept to the original plan timescales

Operational performance

The Trust is committed to delivering the national requirements and operational performance standards. These are robustly monitored and managed to ensure patients receive the most appropriate levels of care. A comprehensive performance management process exists across the Trust to monitor delivery against these standards alongside trust wide organisational efficiently metrics and other quality-based indicators of effective standards of care.

The framework we employ is multi-faceted and covers many levels across the organisation. This includes weekly review at the Chief Operating Officer's performance meeting and through subsequent meetings across the divisions. A detailed Integrated Quality and Performance Report (IQPR) is produced monthly; performance is discussed in-depth at the monthly Finance and Performance Committee, which is chaired by a Non-executive Director, with further scrutiny taking place at the full Trust Board. These have continued to be produced, reviewed and monitored throughout the impact of the COVID-19 pandemic.

Emergency planning / resilience

The Emergency Preparedness, Resilience and Response (EPRR) agenda has dominated NHS organisations in 2020/2021. This is a collective result of COVID-19 response command structures, and the management of several concurrent risks and incidents including, the end of EU Transition Period and influenza.

COVID-19 is a realisation of the highest scored item on the UK Government National Risk Register – Pandemic. However, the root cause infection was not the long-anticipated influenza pandemic, but a novel corona virus. The virus continues to present NHS Providers with substantial clinical challenges in its treatment and containment, including the supply and safe use of personal protective equipment and demand for critical care services.

The Trust already has a well-established, command and control structure in place; which is effectively being used, and has been since the start of the Trust's response to COVID-19. The Trust's Incident Control Centre (ICC) has been operating seven days a week since March 2020.

As part of COVID-19 infectious disease outbreak, as part of the ongoing response to this civil emergency, the Trust is working in collaboration with the local health care economy through formal standing meetings and ad-hoc arrangements. Emergency

planning arrangements have been invoked. This includes being involved in multi-agency command structures to co-ordinate key areas of focus, manage risks and support timely decision making and responding to the many national countermeasures.

Due to the pressures presented by COVID-19, business continuity management has been evoked, as planned staffing remains under pressure and supply chain of essential equipment has at times been tested to the extreme. A COVID-19 email box was established and is still in situ and monitored by emergency planning to manage the flow of information, supported by a series of subject matter experts who receive requests and respond.

The Trust has established plans in place supported by service continuity plans, with further updates being planned for. It should be noted that a number of training, exercises and testing events have been cancelled due to the COVID-19 response. The Trust events will be rescheduled at an appropriate time.

Other activities have been undertaken to improve emergency preparedness response for the Trust; development of a Trust induction DVD on emergency preparedness for all staff, improvement of EPRR intranet site and the development of an electronic grab pack for Strategic and Tactical commanders to use in the event of responding to an emergency incident.

EU Exit. From the 1 February 2020 the UK entered into a transition period which started the withdrawal process from the EU until the 31 December 2020. Due to the many different EPRR steams the NHS adopted a single operational response model to respond to the EU Exit, COVID-19 and winter pressures. The EU Exit transition period has now ended with nil impact reported to the Trust to date. However, the Trust has continued to maintain its current level of preparedness in case of potential further impacts on service delivery over coming months.

EPRR Assurance. The assurance process changed slightly due to COVID-19. The Trust in 2019/2020 EPRR Core Standards self-assessment achieved a fully compliant status, these are continually under review.

The Trust has responded well to the many challenges that have been presented and continues to improve its response, COVID-19 being the biggest challenge.

An Emergency Preparedness Response & Resilience Annual Report has been produced identifying the Trust's resilience and key priorities for the forthcoming year.

Health and safety at work

The Trust Health and Safety risk profile has been maintained and shows compliance with relevant Health and Safety Executive (HSE) legislation. Work continues to identify gaps and provide action plans to fill these gaps giving the Board an improved assurance around compliance with the Regulations. Estates and Facilities continue to work towards compliance with the Premises Assurance Model (PAM) accreditation system, this is adding to the robustness of assurance received from Estates.

During 2020/21 there has been a focus on ensuring COVID-19 safe risk assessments are in place for staff who continue to work on site, and this will continue into 2021/22 as more staff return to work.

There has been an 18.1% reduction in the number of health and safety incidents when comparing 2019/20 to 2020/21. Total incidents reduced from 597 in 2029/20 to 489 in 2020/21. Focus has remained on the high incident reporting areas; ensuring investigations are undertaken where needed and risk assessments reviewed to improve control measures. Emphasis continues on sharing lessons identified across the Trust, using various forums, including the Safety Representative Forum, and our risk newsletter 'Risky Business' and direct email depending which method is felt most suitable at the time.

The top five reported health and safety related incidents for the year are:

Category	2019/20	2020/21	DoT
Slips, trips & falls - Staff	197	147	↑
Sharps injury	196	179	↑
Contact	122	74	↑
Manual handling activity	80	91	→
Hazardous substances	59	64	→

An additional category to highlight which has shown a deterioration is Occupational Health:

Category	2919/20	2020/21	DoT
Occupational health	21	72	↓

Occupational health incidents for this reporting period.

- Face mask irritations/allergy
- Potential outbreaks of COVID-19.

Social economic responsibilities: Modern slavery and forced labour

The Trust sources its procurement function the Integrated Supplies & Procurement Department (ISPD) based at University Hospitals North Midlands which is committed to:

- Utilise the Sustainable Procurement Flexible Framework (SPFF) to facilitate the procurement of goods and services in a more innovative, sustainable manner. This self-assessment mechanism allows each Trust to measure and monitor progress on sustainable procurement over time. All Trusts are aiming for year on year improvements to achieve and work through the actions in the SPFF, working through the levels from Foundation Level 1 to achieve Lead Level 5 by 2021-22.
- Purchase more goods from sustainable sources, with a focus on those from local, ethical and Fair-Trade Suppliers, reducing carbon emissions and improving labour standards are very important areas for the health and social care sector as a whole. All Trusts have an ethical duty to protect and promote health and wellbeing and contract with suppliers of goods and services that operate in a socially responsible way with good environmental practices and employment practices.

The Trusts will use Ethical Procurement for Health (EPH) to support this. Products used will have sustainable specifications using Government Buying standards and Green Public Procurement criteria. The Trusts aim to use their buying power to generate social benefits and consider economic, social and environmental wellbeing when negotiating public service contracts as enshrined in the Public Services (Social Value) Act 2012.

In addition, the NHS Terms & Conditions of Contract for goods & services specify the following terms for suppliers to adhere to in relation to Equality & Human Rights:

- Ensure that (a) it does not, whether as employer or as provider of the Services, engage in any act or omission that would contravene the Equality Legislation, and (b) it complies with all its obligations as an employer or provider of the Services as set out in the Equality Legislation and take reasonable endeavours to ensure its Staff do not unlawfully discriminate within the meaning of the Equality Legislation; in the management of its affairs and the development of its equality and diversity policies, cooperate with the Authority in light of the Authority's obligations to comply with its statutory equality duties whether under the Equality Act 2010 or otherwise. The Supplier shall take such reasonable and proportionate steps as the Authority considers appropriate to promote equality and diversity, including race equality, equality of opportunity for disabled people, gender equality, and equality relating to religion and belief, sexual orientation and age; and the Supplier shall impose on all its Sub-contractors and suppliers, obligations substantially similar to those imposed on the Supplier.

Annual declarations

The Royal Wolverhampton NHS Trust is required to register with the CQC and its current registration status is active. The Royal Wolverhampton NHS Trust has no conditions with its continued registration.

The CQC has not taken enforcement action against The Royal Wolverhampton NHS Trust during 2020/21.

The Trust has published through a link 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 risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust made its annual self-assessment submission to the Department of Health as per the revised required timescales of the Information Governance Toolkit. (see Data Protection and security Toolkit Return section of this report).

Head of internal audit opinion

"Our overall opinion for the period 1 April 2020 to 31 March 2021 is that based on the scope of reviews undertaken and the sample tests completed during the period, Significant assurance with some improvement required can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The level of non-compliance in certain areas puts some system objectives at risk. We identified weaknesses which put system objectives at risk in relation to the Primary Care Governance, Continuous Quality Improvement, the Allocate system and Consultant Job Planning. Otherwise, there are only minor weaknesses in the risk management activities and controls designed to achieve the risk management objectives required by management. Those activities and controls that we examined were operating with sufficient effectiveness to provide reasonable assurance that the related risk management objectives were achieved during the period under review."

Review of effectiveness of risk management and internal control

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 committee and governance & quality committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is informed by reports from external inspecting bodies including external audit and the Patient-Led Assessments of the Care Environment (PLACE) inspections (the system for assessing the quality of the patient environment). It is also informed by comments made by the External Auditors in their report to those charged with governance (ISA 260) and other reports. I have been advised on the implications of the result of my review of effectiveness of the system of internal control by the Trust Board, the Audit Committee, and the QGAC and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board has continued to undertake regular development meetings throughout the year and has recently commenced a review to inform future Board development. It has monitored the performance and effectiveness of the Trust Board Committee's including the Audit Committee, Finance and Performance Committee, the Quality Governance Assurance Committee and the Workforce and Organisational Development Committee all of which have key roles in the assessment of assurance and effectiveness of the Trust and in the identification of and mitigation of any identified risks.

The Audit Committee has managed on behalf of the Trust Board the agreed programme of Audit including internal audit, external audit and clinical audit (alongside the Quality Governance Assurance Committee). The Board receives the presentation of examples of clinical audit work.

In relation to the Well-led Framework – the Trust undertakes continuous monitoring and self-assessment against the framework alongside the outcomes of inspections.

I have not identified any significant internal control issues or gaps in control from the work and assurances provided to me and to the Trust Board.

Conclusion

No significant internal control issues have been identified during 2020/21.

Accountable Officer: Prof. David Loughton CBE

Organisation: The Royal Wolverhampton NHS Trust,

Date: 9 June 2021

B2 – Remuneration and staff report

Staff report

The following tables summarise the numbers and categories of staff, sickness absence and exit packages made during 2019-2020:

Table 18 – Exit package cost banding 2020/21

Exit Package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£000s	Number	£000s	Number	£000s	Number	£000s
<£10,000			19	55	19	55	1	
£10,000 - £25,000	1	18	2	23	3	41		
£25,001 - £50,000	1	29			1	29		
£50,001 - 100,000	1	56			1	56		
£100,001 - £150,000								
£150,001 - £200,000								
>£200,000								
Total	**3**	**104**	**21**	**78**	**24**	**182**	**0**	**£0.00**

The Trust had nil non-contracted payments in lieu of notice in 2020/21.

Table 19 – Exit package cost banding 2019-2020

Exit Package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£000s	Number	£000s	Number	£000s	Number	£000s
<£10,000	3	14,928	19	67,394	22	82,322		
£10,000 - £25,000	5	97,880	1	14,034	6	111,914		
£25,001 - £50,000	9	329,643			9	329,643		
£50,001 - 100,000	6	404,897			6	404,897		
£100,001 - £150,000	1	145,752			1	145,752		
£150,001 - £200,000					0	0		
>£200,000					0	0		
Total	**24**	**993,100**	**20**	**£81,428**	**44**	**£ 1,074,528**	**0**	**£ 0**

Table 20 – Average staff numbers

Average number of employees (WTE basis)

	Total 2020/21 No.	Permanent 2020/21 No.	Other 2020/21 No.	Total 2019/20 No.
Medical and dental	1,085	1,034	51	1,051
Administration and estates	1,268	1,153	115	1,237
Healthcare assistants and other support staff	3,239	3,021	218	3,035
Nursing, midwifery and health visiting staff	2,537	2,439	98	2,364
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	677	673	4	658
Healthcare Science Staff	488	480	8	492
Total average numbers	**9,294**	**8,800**	**494**	**8,838**
Of which:				
Number of employees (WTE) engaged on capital projects	0			0

Table 21 – Staff sickness absence

This data has been taken out of our NHSI return, with the below guidance;

For 2020/21 staff sickness absence data is not required by the FT ARM or DHSC GAM to be disclosed in annual reports. This disclosure may be replaced with a link to where information is published by NHS Digital: https://digital.nhs.uk/data-and- information/publications/statistical/nhs-sickness-absence-rates

Consultancy services

During 2020-21 we spent £1.6m on consultancy services (2019-20 £1.4m). The Trust employed 11 senior managers during the year ending 31 March 2021.

Remuneration report and policy

The Trust has a Remuneration Committee whose role is to advise the Board on appropriate remuneration and terms of service for the Chief Executive and other Executive Directors.

Membership of the Committee, chaired by the Deputy Chair and comprised of the Chairman and all Non-Executive Directors except the Senior Independent Director who remains available in case of dispute.

Remuneration for the Trust's Executive Directors is set by reference to job scope, personal responsibility and performance. This has also accounted for the comparison with remuneration levels for similar posts, within the National Health Service, as well as taking into consideration the national guidance & benchmarking framework. Whilst performance was considered in setting and reviewing remuneration, there are currently no arrangements in place for "performance related pay".

It is not the Trust's policy to employ Executive Directors on "rolling" or "fixed term" contracts. All Directors' contracts conform to NHS standard for directors, with arrangements for· termination in normal circumstances by either party with written notice of six months.

Remuneration for the Trust's Executive and Non-Executive Directors during the financial year ended 31 March 2021 is set out in the attached schedules.

Signature:

Prof. David Loughton, CBE

Date: 9 June 2021

Salary and pension entitlements of senior managers

These tables are subject to audit review.

A) Remuneration

	2020-21					2019-20				
	Salary	Other Remuneration	Expense Payments (taxable) Benefits in Kind	All pension related benefits	Total	Salary	Other Remuneration	Expense Payments (taxable) Benefits in Kind	All pension related benefits	Total
Name and Title	(bands of £5000)	(bands of £5000) £000	Rounded to the nearest £100	(bands of £2,500)	(bands of £5,000)	(bands of £5000)	(bands of £5000) £000	Rounded to the nearest £100	(bands of £2,500)	(bands of £5,000)
Executive Directors										
D Loughton - Chief Executive	255-260	5-10[1]	0	2.5-5	260-265	250-255	0	0	0[1]	250-255
A Cannaby - Chief Nursing Officer	145-150	0	0	30-32.5	175-180	145-150	0	0	107.5-110	250-255
G Nuttall - Chief Operating Officer	155-160	10-15[1]	0	17.5-20	185-190	150-155	0	0	10-12.5	160-165
J Odum - Chief Medical Officer	155-160	80-85 [1 2]	0	20-22.5	255-260	155-160	75-80[2]	0	0-2.5	230-235
K Stringer - Chief Financial Officer and Deputy Chief Executive	160-165	10-15[1 3]	0	0	175-180	155-160	15-20[3]	0	0	175-180
Non-Executive Directors										
S Field - Chairman (from 01/04/2019)	35-40	0	0	0	35-40	35-40	0	0	0	35-40
R Dunshea - Non-Executive Director	10-15	0	0	0	10-15	10-15	0	0	0	10-15
D Edwards - Non-Executive Director	10-15	0	0	0	10-15	10-15	0	0	0	10-15
J Hemans - Non-Executive Director	10-15	0	0	0	10-15	10-15	0	0	0	10-15
M Martin - Non-Executive Director	10-15	0	0	0	10-15	10-15	0	0	0	10-15
D Oum - Non Executive Director (from 01/10/2019 to 09/10/2020)	5-10	0	0	0	5-10	0-5	0	0	0	0-5
A Pandyan - Non Executive Director (from 01/12/2019)	10-15	0	0	0	10-15	0-5	0	0	0	0-5
S Rawlings - Non-Executive Director	10-15	0	0	0	10-15	5-10	0	0	0	5-10
L Toner - Non Executive Director (from 01/11/2019) 10-15	10-15	0	0	0	10-15	0-5	0	0	0	0-5
Directors - Non Voting										
A Duffell - Director of Workforce	135-140	0	0	22.5-25	155-160	130-135	0	0	12.5-15	145-150
S Evans - Director of Communications (from 11/01/2021)	10-15	0-5[1]	0	7.5-10	25-30	0	0	0	0	0
S Evans - Director of Strategic Planning and Performance (from 01/10/2019)	130-135	0	0	90-92.5	220-225	55-60	0	0	97.5-100	150-155
S Mahmud - Director of Innovation, Integration and Research	140-145	0	0	0	140-145	130-135	0	0	0	130-135
T Palmer - Director of Midwifery (from 01/03/2021)	5-10	0	0	45-47.5	50-55	0	0	0	0	0
M Sharon[4] - Strategic Advisor to the Board	95-100	5-10[1]	0	0	100-105	115-120	0	0	0	115-120

Please note:-

1. This relates to remuneration following the selling of annual leave in line with the Trust's Buying and Selling of Annual Leave scheme for all staff.
2. This relates to the Medical Director's role as a Renal Physician
3. This relates to pension contribution payments received, where payments are linked to national guidance and have been approved by the Trust's remuneration committee.
4. This Director retired and returned in April 2018 and is now in receipt of their pension. From October 2019 this Director is now working part time.

Total remuneration for senior managers in year ended 31 March 2021 was £1,664,687 0.22% of income (31 March 2020 £1,505,408, 0.22% of income).

The definition of senior managers used to establish who should be included in the table above is that given in the Group Accounting Manual:
"those persons in senior positions having authority or responsibility for directing or controlling the major activities within the group body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments."

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.

B) Pension benefits

Name and title	Real increase in pension at pension age (bands of £2500)	Real increase in pension lump sum at pension age (bands of £2500)	Total accrued pension at pension age at 31 March 2021 (bands of £5000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5000)	Cash Equivalent Transfer Value at 1 April 2020 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Employer's Contribution to Stakeholder Pension £000
D Loughton[1] - Chief Executive	0-2.5	2.5-5	85-90	265-270	0[1]	0[1]	0[1]	0
A Cannaby[2] - Chief Nursing Officer	2.5-5	0-2.5	50-55	135-140	1,024	36	1,102	0
A Duffell - Director of Workforce	0-2.5	5-7.5	30-35	95-100	735	44	811	0
S Evans[2] - Director of Communications (from 11/01/2021)	0-2.5	0	10-15	15-20	43	12	134	0
S Evans[2] - Director of Strategic Planning and Performance	2.5-5	7.5-10	25-30	50-55	358	70	453	0
S Mahmud[3] - Director of Innovation, Integration and Research	0	0	0	0	0	0	0	0
G Nuttall[2] - Chief Operating Officer	0-2.5	0	65-70	145-150	1,239	29	1,311	0
J Odum - Medical Director	0-2.5	5-7.5	60-65	185-190	1,425	57	1,527	0
T Palmer - Director of Midwifery (from 01/03/2021)	0-2.5	0-2.5	30-35	95-100	634	0	711	0
M Sharon[4] - Strategic Advisor to the Board	0	0	0	0	0	0	0	0
K Stringer[5] - Chief Financial Officer and Deputy Chief Executive	0-2.5	0	65-70	200-205	1,567	0	1,625	0

1. The real increase in Cash Equivalent Transfer Value is not applicable for D Loughton given that he is over pension age.
2. The Director has changed pension scheme membership and as a result the benefits have been calculated as the aggregate of the new scheme and previous schemes.
3. Relates to Directors that opted out of the Pension scheme and their prior years benefit was also withdrawn.
4. Relates to a Director that is in receipt of their pension.
5. Relates to a Director that opted out of the Pension scheme and has opted back in within the financial year. The benefits have been calculated as the aggregate of the new scheme and previous schemes.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

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. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV – This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. The method used to calculate the Real Increase in CETV has changed, to remove the adjustment for Guaranteed Minimum Pension (GMP) on 8 August 2019.

Fair pay disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The median remuneration of the workforce for 2020-21 was £27.0k (2019-20, £26.2k). This was 9.5 times (2019-20, 9.6 times) of the midpoint banded remuneration if the highest paid director

In 2020-21, no employee (2019/20, 2) received remuneration in excess of the highest-paid director. Remuneration ranged from £7.2k to £257.5K [mid-point banded] (2019-20 £5.8k to £252.5k [mid-point banded]). Remuneration as quoted above is based on basic salary only of staff in post as at 31st March 2021 including bank and agency staff. It does not include employer pension contributions or the cash equivalent transfer value of pensions.

Annualised remuneration may not reflect actual remuneration in year, for example where an individual was in post for only part of the year. The Executive Director payments are variable and may change from one year to another, subject to approval through the Trust Remuneration Committee to the Board. The vast majority of Trust employees are subject to national pay settlements and have, in accordance with those national settlements, received an inflationary increase in pay in 2019/20 of 3.8% and where applicable, employees have continued to make incremental progression within existing pay scales.

Off payroll engagements

Recruitment is properly devolved to Trust managers who are required link with the Workforce Department to ensure that all off payroll engagements are subject to appropriate assessments regarding IR35 status.

For all off-payroll engagements as of 31 March 2021, for more than £245 per day and that last for longer than six months.

Number of existing engagements as of 31 March 2021.	0
Of which, the number that have existed.	
For less than one year at time of reporting.	
For between one and two years at time of reporting.	
For between 2 and 3 years at time of reporting.	
For between 3 and 4 years at time of reporting.	
For 4 or more years at time of reporting.	

For all new off-payroll engagements, or those that 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.

Number of temporary off-payroll workers engaged between 1 April 2020 and 31 March 2021	5
Of which...	
Number not subject to off-payroll legislation (see note)	0
Number subject to off-payroll legislation and determined as in-scope of IR35 (see note).	5
Number subject to off-payroll legislation and determined as out of scope of IR35 (see note).	0
Number of engagements reassessed for compliance or assurance purposes during the year.	0
Of which, number of engagements that saw a change to IR35 status following 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

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	
Total number of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	19

Staff sharing arrangements

The Trust has no staff subject to such arrangements.

C – Financial statement

Forward and financial performance overview

The summary financial statements are an extract of the information in the full annual accounts. These include the Annual Governance Statement of the Trust for year ended 31 March 2021. The summary financial statements only give an overview of the financial position and performance of the Trust but might not contain sufficient information for a full understanding of the Trust's performance. For more detailed information please refer to the full annual accounts for the Trust. These are available free of charge from The Chief Financial Officer, The Royal Wolverhampton NHS Trust, New Cross Hospital, Wolverhampton, WV10 0QP.

The annual accounts have been prepared in accordance with the 2020/21 Department of Health and Social Care Group Accounting Manual (GAM). From 2009/10 the GAM follows the International Financial Reporting Standards (IFRS) and interpretations to the extent that they are meaningful and appropriate to public body entities.

The financial performance of the Trust is assessed by the Department of Health and Social Care against four targets. These are:

- **Income and expenditure**
  As a minimum, the Trust is required to break even each year. Where a deficit is incurred, the Trust is required to achieve surpluses in subsequent years until break-even, taking one year with another, is achieved.
- **Capital cost absorption rate**
  Within its overall expenditure, the Trust is required to pay the Department of Health and Social Care a sum equivalent to 3.5% of average net relevant assets. This payment is known as the Public Dividend Capital payment.
- **External financing limit:**
  This refers to the agreed amount of cash that the Trust is allowed by the Department of Health and Social Care to consume over and above the amount it generates through its normal activities in year. This may be through a reduction in its own cash balances or receiving cash from external sources. The Trust is expected to not exceed its External Finance Limit (EFL) and in 2020-21 it achieved this, spending (£12,982,000) (against a target of (£7,370,000)).
- **Capital resource limit**
  This is a limit, imposed by the Department of Health and Social Care, on the level of capital expenditure that the Trust can incur in the year. The Trust is expected to maintain its spend at or below this level. For 2020/2021 there is an underspend against CRL of £801,000 which was expected from NHSI/E. This underspend is PDC paid to the Trust (in June 20) in respect of costs the Trust incurred in 2019/2020 and self-funded. The PDC paid over in 2020/2021 was a 'cash top-up' and the Trust has prudently used the PDC to reimburse its cash balances.

Table 22

	Target	Actual	Achieved
Income & Expenditure Break-even (£'000)	(3,800)	243	✓
Capital Cost Absorption Rate (%)	3.50%	3.50%	✓
External Financing Limit (£'000)	(7,370)	(12,982)	✓
Capital Resource Limit (£'000)	50,701	49,900	✓

* Target is adjusted control total as agreed with NHSi

Table 23 – The Income and expenditure position for each of the last five years:

	2016/17 £000s	2017/18 £000s	2018/19 £000s	2019/20 £000s	2020/21 £000s
Breakeven duty in-year financial performance	8,542	4,327	3,021	5,735	243
Breakeven duty cumulative position	46,795	51,122	54,143	59,877	60,121
Operating income	536,029	548,538	592,975	676,114	743,285
Cumulative breakeven position as a percentage of operating income	8.73%	9.32%	9.13%	8.86%	8.09%

Cumulative position

Table 23 shows that the trust achieved its statutory break-even duty in 2020-21. In 2020-21 the Trust achieved a surplus for the 15th consecutive year. This surplus amounted to £243k after impairment and adjustments for changes in accounting treatment.

Private finance transaction

The Trust has an on-balance sheet scheme relating to the provision and maintenance of the Radiology building and equipment including replacement and upgrading. The contract for the scheme covers the period 1 April 2002 to 31 March 2032. Although the interest rate changes affect future performance, the impact to date has not been significant.

Better payment practice code

The Department of Health requires that Trusts aim to pay their non-NHS invoices by the due date or within 30 days of receipt of goods or a valid invoice, (whichever is the latter), unless other terms have been agreed with the supplier. The target is to achieve 95% compliance and, over the last two years, the Trust's performance is shown in table 24.

Table 24 – Better payment practice code summary

	2020/21		2019/20	
	Number	£'000	Number	£'000
Total invoices paid in year	117,367	401,505	117,329	361,375
Total invoices paid within target	90,945	337,948	46,585	218,165
Percentage of invoices paid within target	77.49%	84.17%	39.70%	60.37%

Prompt payment code

The Trust is an approved signatory to the prompt payment code.

Staff sickness absence

The following table provides details of the Trusts Sickness Absence

Table 25 – Staff sickness absence

This data has been taken out of our NHSI return, with the below guidance;

From 2019/20 staff sickness absence data is not required by the FT ARM or DHSC GAM to be disclosed in annual reports. This disclosure may be replaced with a link to where information is published by NHS Digital: https://digital.nhs.uk/data-and- information/publications/statistical/nhs-sickness-absence-rates

Pension liabilities

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsba.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FRem requires that ''the period between formal valuations shall be four years, with approximate assessments in intervening years". Further details can be found in the full set of accounts available on request.

Accounting policies

The accounts for the Trust were produced in line with the Department of Health and Social Care Group Accounting Manual. Full details of the accounting policies are included within the Trust annual accounts which are available on request. Particular areas where judgement has had to be exercised are:

- Useful economic lives of assets – The Trust estimates the useful economic lives of its non-current assets. Every care is taken to ensure that estimates are robust; however, factors such as unforeseen obsolescence or breakdown may impact on the actual life of the asset held. It should be noted that in 2015/16 the Trust changed the asset life methodology for buildings to a Single Residual Life Methodology, resulting in a reduction to annual depreciation.
- Provisions – When considering provisions for events such as pension payments, NHSLA claims and other legal cases the Trust uses estimates based on expert advice from agencies such as the NHS Litigation Authority and the experience of its managers.
- Leases – The Trust applies the tests contained in IAS17 to all of its present and proposed leases in order to ascertain if they should be classed as operating or finance leases. Often the information available may be inconclusive and therefore judgement is made regarding the transfer of the risks and rewards of ownership of the associated assets in order that a decision may be made. There have been no major policy changes that have impacted on the position of the Trust. Additionally, the Trust is required to adopt accounting standard IAS27 which requires the Trust to consolidate its Charitable Funds into accounts if material. These were not consolidated as they are not considered material.

Financing

Auditors

The Trust's external auditors are KPMG LLP. The total charge for audit work undertaken in 2020-21 was £66k excluding VAT (2019-20 £63k). Other auditors' remuneration in 2020-21 was £10k (2019-20 £6k) and is in respect of non-audit services. As far as the directors are aware, there is no relevant audit information the Trust's auditors are unaware of and the Directors have taken all steps that they ought to have taken, as Directors, to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information. Non-audit work may be performed by the Trust's external auditors where the work is clearly audit related and the external auditors are best placed to do that work. For such assignments the Audit Committee approved protocol is followed. This ensures that all such work is properly considered and that the external auditor's independence is not compromised through the Trust using them for other non-audit services.

The Trust is able to ensure this as:

- All work is controlled and monitored by the Audit committee which is made up of Non-Executive Directors. They approve all work and provide a check to ensure independence is maintained.
- Any additional work carried out by the external auditors has to be approved by the Audit Commission if its value is greater than 20%.

Table 26 – Statement of comprehensive income for the year ended 31 March 2021

	2020-21	2019-20
	£000s	£000s
Operating income from patient care activities	588,601	549,223
Other operating income	154,684	126,891
Operating expenses	(734,130)	(656,732)
Operating surplus/(deficit) from continuing operations	9,155	19,382
Finance income	26	186
Finance expenses	(2,105)	(2,126)
PDC dividends payable	(10,003)	(10,589)
Net finance costs	(12,082)	(12,529)
Other gains / (losses)	34	53
Surplus / (deficit) for the year	(2,893)	6,906

Table 27 – Other comprehensive income for the year ended 31 March 2021

	2020-21	2019-20
Will not be reclassified to income and expenditure:	£000s	£000s
Revaluations	12,488	3,561
Total comprehensive income / (expense) for the period	9,595	10,467

Table 28 – Financial performance for the year ended 31 March 2021

	2020-21	2019-20
	£000s	£000s
Retained surplus / (deficit) for the year	(2,893)	6,906
Impairments (Excluding IFRIC 12 Impairments)	5,658	(1,408)
Adjustments in respect of donated gov't grant asset reserve elimination	(1,709)	156
Remove 2018/19 post audit PSF reallocation (2019/20 only)	0	(511)
Remove net impact of inventories received from DHSC group bodies for COVID response	(813)	0
Adjusted retained surplus / (deficit)	243	5,143

Table 29 – Statement of financial position as at 31 March 2021

	31 March 2021	31 March 2020
	£000s	£000s
Non-current assets		
Intangible assets	**5,526**	2,609
Property, plant and equipment	**382,916**	348,384
Trade and other receivables	**7,326**	6,532
Total non-current assets	**395,768**	357,525
Current assets		
Inventories	**8,802**	6,901
Trade and other receivables	**29,136**	60,820
Cash and cash equivalents	**54,351**	12,045
Total current assets	**92,289**	79,766
Current Liabilities		
Trade and other payables	**(79,979)**	(68,910)
Borrowings	**(2,012)**	(2,032)
Provisions	**(4,592)**	(5,084)
Other liabilities	**(3,659)**	(3,300)
Total current liabilities	**(90,242)**	(79,326)
Total assets less current liabilities	**397,815**	357,965
Non-current liabilities		
Trade and other payables	**(58)**	(68)
Borrowings	**(5,576)**	(7,223)
Provisions	**(2,399)**	(1,859)
Total non-current liabilities	**(8,033)**	(9,150)
Total assets employed	**389,782**	348,815
Financed by		
Taxpayers' equity		
Public dividend capital	**282,017**	250,646
Revaluation reserve	**76,872**	64,384
Other reserves	**190**	190
Income and expenditure reserve	**30,703**	33,595
Total taxpayers' equity	**389,782**	348,815

The financial statements were approved by the Board on 1 June 2021 and signed on its behalf by:

Prof. David Loughton CBE, Chief Executive

Date: 9 June 2021

Table 30 – Statement of changes in taxpayers' equity for the year ending 31 March 2021

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000s	£000s	£000s	£000s	£000s
Taxpayers' equity at 1 April 2020 - brought forward	**250,646**	**64,384**	**190**	**33,595**	**348,815**
Surplus / (deficit) for the year	0	0	0	(2,893)	**(2,893)**
Revaluations	0	12,488	0	0	**12,488**
Public dividend capital received	31,371	0	0	0	**31,371**
Taxpayers' equity at 31 March 2021	**282,017**	**76,872**	**190**	**30,703**	**389,782**

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

Retained earnings

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

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.

Other reserves

Other reserves arose at the time of inception of the Trust and are considered likely to remain at the present value.

Table 31 Statement of cash flow for the year ended 31 March 2021

	2020-21	2019-20
	£000s	£000s
Cash flows from operating activities		
Operating surplus / (deficit)	**9,155**	19,382
Non-cash income and expense:		
Depreciation and amortisation	**21,230**	20,508
Net impairments	**5,658**	(1,327)
Income recognised in respect of capital donations	**(1,949)**	(102)
(Increase) / decrease in receivables and other assets	**31,355**	(26,314)
(Increase) / decrease in inventories	**(1,901)**	(294)
Increase / (decrease) in payables and other liabilities	**4,946**	14,826
Increase / (decrease) in provisions	**54**	1,792
Net cash generated from / (used in) operating activities	**68,548**	28,471
Cash flows from investing activities		
Interest received	**26**	186
Purchase of intangible assets	**(3,681)**	(646)
Purchase of property, plant, equipment and investment property	**(39,784)**	(31,223)
Sales of property, plant, equipment and investment property	**34**	53
Receipt of cash donations to purchase capital assets	**179**	102
Net cash generated from / (used in) investing activities	**(43,226)**	(31,528)
Cash flows from financing activities		
Public dividend capital received	**31,371**	13,461
Capital element of finance lease rental payments	**(211)**	(165)
Capital element of PFI, LIFT and other service concession payments	**(1,836)**	(1,818)
Interest paid on finance lease liabilities	**(16)**	(13)
Interest paid on PFI, LIFT and other service concession obligations	**(2,094)**	(2,116)
PDC dividend (paid) / refunded	**(10,230)**	(10,234)
Net cash generated from / (used in) financing activities	**16,984**	(886)
Increase / (decrease) in cash and cash equivalents	**42,306**	(3,943)
Cash and cash equivalents at 1 April - brought forward	**12,045**	15,988
Cash and cash equivalents at 31 March	**54,351**	12,045

1. Public Dividend Capital dividend – this is a payment made to the Department of Health and Social Care, representing a 3.5% return on the Trust's net relevant assets.
2. Revenue from activities – this is the majority of the Trust's income and is derived in the main from the provision of healthcare to Commissioners.
3. Other operating revenue – is mostly in respect of training and research and development
4. Intangible assets – this relates to software licences
5. Tangible assets – this refers to the Trust's land, buildings and equipment
6. Provisions for liabilities and charges – when there is a reasonable degree of certainty that the Trust will be liable for a particular cost, and where it has not yet actually been incurred, a provision is made to reflect that liability
7. Impairment – this term is most usually applied when a decision has been made that reduces the life and / or value of a Trust asset (most often a building). Such reductions in value are charged to the income and expenditure account when there are insufficient balances on the revaluation reserve.

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, other items of comprehensive income and cash flows for the year.

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 the entity's auditors are aware of that information.

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.

Prof. David Loughton, Chief Executive Officer

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, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- Apply on a consistent basis the 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 which 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. 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

Prof. David Loughton, Chief Executive

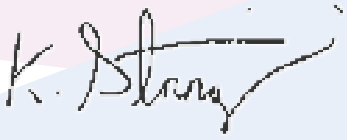
Certification on summarisation schedules

Trust Accounts Consolidation (TAC) summarisation schedules for The Royal Wolverhampton 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 no validation errors.
3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS.



Kevin Stringer, Chief Finance Officer

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.

Prof. David Loughton, Chief Executive

English

If you need information in another way like easy read or a different language please let us know.

If you need an interpreter or assistance please let us know.

Lithuanian

Jeigu norėtumėte, kad informacija jums būtų pateikta kitu būdu, pavyzdžiui, supaprastinta forma ar kita kalba, prašome mums apie tai pranešti.

Jeigu jums reikia vertėjo ar kitos pagalbos, prašome mums apie tai pranešti.

Polish

Jeżeli chcieliby Państwo otrzymać te informacje w innej postaci, na przykład w wersji łatwej do czytania lub w innym języku, prosimy powiedzieć nam o tym.

Prosimy poinformować nas również, jeżeli potrzebowaliby Państwo usługi tłumaczenia ustnego lub innej pomocy.

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਰੂਪ ਵਿਚ, ਜਿਵੇਂ ਪੜ੍ਹਨ ਵਿਚ ਆਸਾਨ ਰੂਪ ਜਾਂ ਕਿਸੇ ਦੂਜੀ ਭਾਸ਼ਾ ਵਿਚ, ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

ਜੇ ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਏ ਦੀ ਜਾਂ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

Romanian

Dacă aveți nevoie de informații în alt format, ca de exemplu caractere ușor de citit sau altă limbă, vă rugăm să ne informați.

Dacă aveți nevoie de un interpret sau de asistență, vă rugăm să ne informați.

Traditional Chinese

如果您需要以其他方式了解信息，如易读或其他语种，请告诉我们。

如果您需要口译人员或帮助，请告诉我们。

Designed & produced by The Department of Clinical Illustration, The Royal Wolverhampton NHS Trust

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NHS
The Royal Wolverhampton
NHS Trust

Annual Accounts 2020/21

Safe & Effective | Kind & Caring | Exceeding Expectation

The Royal Wolverhampton NHS Trust

Annual accounts for the year ended 31 March 2021

The Royal Wolverhampton NHS Trust - Annual Accounts 2020-21

CONTENTS

Foreword to the Accounts

Financial Review - year ended 31 March 2021

The Financial results achieved by the Trust are shown in the table below. In common with all NHS trusts we are required to meet a number of financial targets set by the Department of Health and Social Care. Our performance against these targets is set out in the table below:

Financial Target	Actual Performance	
	2020-21	2019-20
To break even on income and expenditure, taking one year with another	Deficit of £2.893m	Surplus of £6.906m
To achieve a capital cost absorption rate of between 3% and 4%	3.5%	3.5%
To operate within an External Financing Limit set by the Department of Health and Social Care	Under-spent by £5.612m	Under-spent by £2.626m
To remain within a Capital Resource Limit set by the Department of Health and Social Care	Underspent by £0.801m*	Breakeven
To pay 95% of non-NHS trade creditors within 30 days	87%	61%

* For 2020-21 there is an underspend against CRL of £0.801m which was expected from NHSI/E. This underspend is PDC paid to the Trust (in June 2020) in respect of costs the Trust incurred in 2019-20 and self-funded. The PDC paid over in 2020-21 was a 'cash top-up' and the Trust has prudently used the PDC to reimburse its cash balances.

K. Stringer

Kevin Stringer
Chief Financial Officer
9 June 2021

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, other items of comprehensive income and cash flows for the year.

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 the entity's auditors are aware of that information.

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.

Signed.....  .....Chief Executive

Date....9 June 2021.....

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

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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 the entity's auditors are aware of that information.

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.

Signed.....  .....Chief Executive

Date....9 June 2021.....

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF THE ROYAL WOLVERHAMPTON NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of The Royal Wolverhampton NHS Trust ("the Trust") for the year ended 31 March 2021 which comprise the Trust Statement of Comprehensive Income, Trust Statement of Financial Position, Trust Statement of Changes in Taxpayers Equity and Trust Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health and Social Care Group Accounting Manual 2020/21.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not 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. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Trust's business model and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the Directors' assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance as a result of the need to achieve specific targets delegated to the Trust by NHS Improvement
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, in particular the risk of incentive for revenue to be manipulated into the wrong period around the year end and the risk that Trust management may be in a position to make inappropriate accounting entries.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals. We consider this risk to be applicable to non-payroll and non-depreciation expenditure.

We did not identify any additional fraud risks.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included combinations of seldom used accounts, postings to fraud risk related accounts, postings between unrelated accounts and journals where segregation of duty could not be demonstrated for authorisation.
- Assessing significant estimates for bias.
- Inspecting transactions in the period prior to and following 31 March 2021 to verify revenue had been recognised in the correct accounting period.
- Inspecting transactions in the period prior to and following 31 March 2021 to verify expenditure had been recognised in the correct accounting period.
- Evaluating accruals posted as at 31 March 2021 and verifying accruals are appropriate and accurately recorded.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through

discussion with the directors and other management (as required by auditing standards), and from inspection of the Trust's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Trust is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. Under paragraph 2(1) of Schedule 5 to the National Health Service Act 2006 the Trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account (the breakeven duty). In reporting on compliance with the breakeven duty the Trust is required to comply with the Department of Health and Social Care's 'Guidance on Breakeven Duty and Provisions', We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

We are also required to make a referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 if 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.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and

- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2020/21. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 5, the directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; 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. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 4 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on 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 if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 5, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by 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 the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- 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 issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Board of Directors of The Royal Wolverhampton NHS 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 Board of the Trust, as a body, 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 Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of The Royal Wolverhampton 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.

Sarah Brown
for and on behalf of KPMG LLP
Chartered Accountants
Birmingham

9 June 2021

GOVERNANCE STATEMENT 2020-2021
Organisational Code: RL4

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.

Partnership

I acknowledge that I must discharge my duty of partnership, and have undertaken this in a number of ways. During this year the majority of the contacts and meetings described in this statement and the Trust Annual Report have taken place virtually, using video and voice conferencing due to the restrictions placed on us all by the pandemic. Despite this, good contact and relationships have been maintained, fostered and enhanced throughout the year.

As Chief Executive, I attend the Wolverhampton City Council Overview and Health Scrutiny Panel where a range of topics have been discussed with local authority elected members. Reflecting our footprint in Staffordshire, I have also engaged with Overview and Scrutiny Panels and Healthwatch within the County of Staffordshire.

During the year a proportion of my time, and that of Director Colleagues, has included continued involvement in the development of Sustainability and Transformation Plans (STP) in both the Black Country and Staffordshire.

There has continued to be close contact with commissioning organisations, and members of my Executive Team and I have attended meetings with Wolverhampton Healthwatch, and the Wolverhampton Health and Wellbeing Board.

Close links have been maintained with NHS England and NHS Improvement (NHSI) through a range of group, individual, formal and informal meetings. I have continued to participate in the meetings of West Midland NHS Provider Trust Chief Executives meetings. All my Executive Directors are fully engaged in the relevant networks, including finance, nursing, medical, operations and human resources.

I am supported in my engagement with partner organisations by the Chairman of the Board, who this year has met with his counterparts at The Dudley Group NHS Foundation Trust, Walsall Healthcare NHS Trust, University Hospital of Birmingham/Heart of England NHS Foundation Trusts, Sandwell and West Birmingham Hospital NHS Trust, The Shrewsbury and Telford Hospital NHS Trust, the University Hospital of North Midlands NHS Trust, Black Country Partnership NHS Foundation Trust, West Midlands Ambulance Service NHS Foundation Trust, as well as regular meetings with local authority members and officers, and other key players in the city's business and third sector communities. He too has taken part in discussions towards further developing the sustainability and transformation plans (STPs).

I have met periodically with the local Members of Parliament and senior members of the national NHS team present and past.

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance with relevant principles of the Code is considered to be good practice. This Governance Statement is intended to demonstrate how the Trust had regard to the principles set out in the Code considered appropriate for the Trust for the financial year ended 31 March 2021.

Black Country and West Birmingham Healthier Futures Partnership (previously STP)
ANNUAL REPORT Statement from the Independent Chair

Serving a population of around 1.5 million people, our partnership is the collaboration across local authorities, NHS bodies and the voluntary and community sector to:

a) improve the health of our population by reducing inequalities in health outcomes and improving the quality of and access to services
b) attract more people to work in health and care in our region through new ways of working, better career opportunities, support and the ability to balance work and home lives
c) work together to build a sustainable health system that delivers safe, accessible care and support in the right locations, in order to get the greatest value from the money we spend.

After an unprecedented year, my biggest reflection is of pride in our heath and care workforce, together with gratitude for all those who have gone above and beyond to care for people at their most vulnerable and protect many more from the impact of COVID-19. Through the challenges of the last 12 months the strength, the compassion, commitment and determination of our people has been outstanding. On behalf of our partnership, thank you for all that you have done and continue to do.

As COVID-19 pressures start to ease, NHS organisations will face the new challenge of restoring services. Whilst we need to ensure people are seen for the care they need in as timely a way as possible, we also have to guarantee that our NHS workforce are supported to rest, decompress and recover from a year of unprecedented demands placed upon them physically and emotionally. Our People Board is focusing on the wellbeing support required to ensure help and assistance are provided for those who were there for so many people when they were needed most.

For local government partners the challenge of enabling communities and people to safely go about their daily lives is key. Testing capacity and support for local businesses will play a vital part in this, as will support for people and families who need extra help to manage their new circumstances. This year, more than ever, the voluntary and community sector has played a really important role, helping people to stay connected to communities and building resilience in the darkest of times. The kind spirit of a few has shone through our communities and been a lifeline for many.

Perhaps the greatest example of our partnership working has been our vaccination programme which continues at pace. Operating from over 30 vaccination locations we rapidly moved through the cohorts of eligibility, starting with those most vulnerable. Whilst uptake has been generally high, we have seen some areas of concern. We know the lower uptake in some areas will be due to a number of factors, including confidence in the vaccine, convenience of access and also complacency with regard to whether people feel the need to be vaccinated. We also know that COVID-19 has disproportionately impacted on our Black, Asian and Minority Ethnic communities and that worryingly, the uptake of the vaccine is also much lower amongst these groups.

To respond to these challenges, we are increasing our efforts to get the right information to people and have where necessary changed the mode of vaccine delivery to improve accessibility. Working with Public Health in each place, we have also created a network of community champions, as well as working with community and faith leaders and also trusted community voices, to help deliver the right messages.

Our partnership exists to benefit local people, and through our continued collaboration and working together, I am confident we can deliver truly integrated health and care services of which everyone in the Black Country and West Birmingham can be justifiably proud. I would like to thank all health and care colleagues throughout our system for their commitment, dedication and hard work during the past year and for their help in bringing this ambition closer to being realised.

Jonathan Fellows, Independent Chair
Black Country and West Birmingham Integrated Care System

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 The Royal Wolverhampton 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 The Royal Wolverhampton NHS Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

The Governance Framework of the Organisation

We have a well-established framework for governance to inform the Trust Board of operational and strategic risks as well as to provide assurance on business performance and compliance. The framework sets in place under the Trust Board a high-level committee and management structure for the delivery of assured governance.

Sub Trust Board assurance committees are constituted to ensure the delegated operation of effective risk management systems, processes and outcomes. These committees inform and assure the Trust Board through the functioning and reporting of sub-groups and specialist working groups defined in their terms of reference.

The Trust maintained risk management processes throughout the year although during the 1st and 2nd wave of the Covid 19 Pandemic there was some adverse impact on meetings and some routine processes as activity pressures increased and staff were redeployed into needed roles.
Some processes were paused for example action follow up, low level risk update, external visit follow up and audits. Focus was maintained on the escalation of risks from service areas, the update of high-level risks and the monitoring and investigation of Covid and other reported incidents.

In May 20 internal audit of Risk Management included review of the design and operation of the Trust's Risk Management Assurance Strategy and arrangements, which is underpinned by the Risk Management and Patient Safety Reporting Policy (OP10). The report concluded partial assurance with 3 medium and 2 low recommendations which included review of risk recording in line with Trust format and strengthening of local minute taking of risk activity. The recommendations are formed into an action plan that is regularly monitored by the Audit Committee.

Trust Board

The Trust Board has met virtually and monthly as planned (except in September 2020 and January 2021, also as planned). Other than for matters requiring commercial confidence or having sensitive patient identifiable or staff identifiable human resources implications, it has conducted its business in public and as soon as was possible, it has made the virtual public Board meeting available to the press, public and other observers. It has been open to questions posted for the Directors at each meeting with responses provided either in or post-meeting.

A high attendance rate by Directors was recorded during the year. The Chairman's term of office commenced from April 2019 and was renewed before the end of the term. At 31 March 2021 the Board comprised 2 female and 6 male Executive Directors (Chief Officers); 1 from a minority ethnic background; and 4 female and 5 male Non- Executive and Associate Non-Executive Directors, 2 from a minority ethnic background.

At each meeting the Trust Board considered reports on:

- Quality and safety
- Serious incidents
- Operational performance

- Financial issues and performance
- The progress of the Financial Recovery Board
- GP Vertical Integration, Innovation and Research
- Reports and minutes from the Trust Board's standing committees
- Cost improvement programme (financial and qualitative delivery – within the Finance Report)
- Mortality (within the Integrated Quality and Performance Report)
- Development of a potential acute collaborative arrangement
- Development of the Wolverhampton Place, the Black Country and South-West Staffordshire Integrated Care Systems (ICS)

The Trust Board receives a monthly Integrated Quality and Performance Report (IQPR) (including national performance measures and 12-month trends). This report includes workforce data such as staff turnover and appraisal rates, metrics relevant to patient experience (such as medication incidents, infection prevention, friends and family test scores and safety thermometer), and those relating to operational performance (such as targets for referral to treatment times, time spent in the Emergency Department, ambulance handover times, cancelled operations and cancer waiting times). The indicators within the report are reviewed annually and approved by the Trust Board. This is added to by the Report of the Chief People Officer.

The Trust Board strives to maintain an appropriate balance between strategic matters and supervising the management of the Trust. Among the former in 2020-2021 were:

- the operational impact and strategic potential impact of the Covid-19 Pandemic
- the medium to long term implications of the Covid-19 Pandemic, recovery and restoration on the services and staff of the Trust
- the support of the senior team operationally managing the Pandemic impact and the support for schemes and investment required as part of the Trust response to the Pandemic
- the support for and recognition of closer working relationships with a wide range of stakeholders and partner organisations as part of the Pandemic response including the City of Wolverhampton local authority and colleagues in the local Public Health team, commissioners and provider partners
- the continued focus on recruitment of key staff particularly doctors and nurses,
- the continued development of innovation programmes and exploration of the use of artificial intelligence, data and technology in improving healthcare,
- the pause and continuation of the development of a clinical quality improvement programme,
- the 5-year capital programme revisions and agile responses to changing capital expenditure priorities,
- the continued development of the University of Wolverhampton Postgraduate Academic Institute of Medicine and partnerships with a range of other academic institutions
- the extension of the Trust's own clinical fellowship programme,
- the continued vertical integration of GP practices and development of the Primary Care Networks and Wolverhampton Place,
- the development of an accountable care organisation,
- the contributions to the development of the sustainability and transformation plans,
- and the ongoing financial challenges within the NHS.

The Trust Board has continued to build on strong relations with stakeholders, including local commissioners, Healthwatch, Public Health and local authority overview and scrutiny committees.

The Non-Executive Directors (NED) are committed to self-development and learning, as evidenced by virtual attendance at events arranged by NHS Improvement (NHSI), NHS Providers, Healthcare Financial Management Associate (HFMA) NED forum, Chair and NED events put on by the Health Services Management Centre, the Good Governance Institute and networking via private firms (particularly legal firms specialising in healthcare law).

Table 13 – Board Composition and Commitment/Experience

Board Governance

- All voting positions substantively filled with considerable experience and continuity of Board members
- Senior Independent Director in position
- Clarity over who is entitled to vote at Trust Board meetings
- At least half of the voting Board of Directors comprises Non-Executive Directors who are independent
- Appropriate blend of NEDs from the public, private and voluntary sectors
- Four NEDs have clinical healthcare experience
- Appropriate balance between Directors who are new to the Trust Board and those who have served for longer
- Majority of the Trust Board are experienced board members
- Chairman has had previous non-executive director experience
- Membership and terms of reference of Trust Board committees reviewed during the year
- Two members of the Audit Committee have recent and relevant financial experience
- Trust Board members have a good attendance record at all formal board and committee meetings, and at other board events.
- A positive result from the independent external review of governance reported in year.

As well as meeting formally, the whole Trust Board meets every month for a development session, this programme has covered a mixture of informal presentations around strategic and operational matters, as well as informal briefings and discussions, such as on financial pressures and service development opportunities in the Black Country. The NEDs have also a programme of Executive Briefings from Chief Officers and senior staff on a variety of matters and from the Chief Executive at least monthly in addition to Board, Board Committee and Development sessions.

Throughout the Covid-19 Pandemic, the Board and Board Committee's, Development sessions and briefings have continued as planned using virtual video conferencing and the shared papers system already in place. On occasion, the length and business have been reduced appropriate to operational pressures and meeting requirements. Information and consultation have also been carried out by email where required and appropriate.

Audit Committee

Members: R Dunshea, M Martin, and R Edwards

The aims of the Committee are to provide the Trust Board with an independent and objective review of its financial systems, financial information, risk management and compliance with laws, guidance, and regulations governing the NHS.

Each meeting received an update on any new risks or assurance concerns from the chairs of the Quality Governance Assurance Committee (QGAC), the Finance and Performance Committee (F&PC) and the Trust Management Committee (TMC). One joint meeting was held with QGAC.

The Committee received and discussed reports on the:

- Annual Report for Trust Charitable Funds 2020-2021
- Trust Annual Report and accounts 2020-2021
- Board Assurance Framework, Strategic Risk Register and related governance processes
- Data security and protection
- Management of sepsis recording
- Radiotherapy case investigation
- Human Tissue Authority procedure compliance
- Consultant Job Planning

Most of the audits and reviews were completed to plan against the constraints caused by the Covid 19 pandemic. Where not completed they were planned for completion early in 2021-22.

These matters featured in the Committee's reports to the Trust Board, including a high-level summary of the Internal Audit reports received at each meeting. The Trust Board have been kept informed of when audit reports showed high or medium risk recommendations requiring management attention, and has been assured that mitigating actions are being taken in accordance with the agreed timeframes.

The Committee also receives regular reports from the Local Counter Fraud Specialist. The Trust currently complies fully with the National Strategy to combat and reduce NHS fraud, having a zero-tolerance policy on fraud, bribery and corruption. The Trust has a counter fraud plan and strategy in place designed to make all staff aware of what they should do if they suspect fraud.

The Committee monitors this strategy and oversees when fraud is suspected and fully investigated. The Committee seeks assurance that appropriate action has been taken, which can result in criminal, disciplinary and civil sanctions being applied. There were no significant frauds detected during the year, although some cases reported to the counter fraud team remain on-going.

The Chair of the Quality Governance Assurance Committee (QGAC) is a member of the Audit Committee, which helps to maintain the flow of information between the two committees, particularly on clinical audit matters. Two of the three Committee members have recent and relevant financial experience.

Non-Executive Directors' attendances were recorded as being high during the year, and the Committee was quorate at each meeting.

Quality Governance Assurance Committee (QGAC)

Members: Chair - R.Edwards, L.Toner, A Pandyan (from November 2020)

Aims & Objectives of the Committee (from ToR)

The aims of the Committee are to provide assurance to the Board of the effective functioning of risk management systems through a reporting framework. The framework reviews care standards and targets, monitors quality and safety performance, identifies risks and escalates as appropriate to the Board.

Committee objectives - During the period QGAC had two primary objectives:
1) That the Trust will have developed during the year metrics which will enable the Board to be assured that it can adequately assess the performance of all the divisions.
2) Mortality:
• To understand the drivers for elevated mortality ratios
• To have a robust improvement plan, including target dates
• To be able to demonstrate that we are providing reliable care

Metrics have been steadily developed and refined. Mortality, which has been the subject of monthly reports, and has been scrutinised as a BAF Risk (SR 12) has now been removed from the BAF, the SHMI having been within expected levels for a sufficient length of time and the reports showing good progress with the action plan.

During 2021 NEDs have discussed future objectives. Linking in with the Trust's Strategic Objectives, QGAC will be considering for 2021-22 objectives featuring: equality of access to health care and equality of outcome; and returning to normal levels of activity in a clinically sound and equitable way.

Frequency of meetings and main focus

During 2020-2021, the Committee met virtually on 9 occasions, with one meeting (January 2021) cancelled. During peak Covid, meetings were reduced to one hour's duration.

Activity and Areas of Activity
At each meeting the Committee received an update on reports in line with its terms of reference (including items below). It escalated risks and assurances to the Board via the chair's report of each meeting and minutes to the trust Board. The list of reports is managed on an annual plan/cycle of work with upward reporting Groups and the Committee maintains an issues log to communicate issues for redress and record action taken.

- Board Assurance Framework (BAF) – Monthly
- Trust Risk Register (TRR) – Monthly
- Integrated Quality and Performance Report – Monthly
- Learning from Deaths – Monthly, up to and including January 2021.
- Information Governance Toolkit
- Continuous Quality Improvement Reports - Annual Update and Q1 Report
- National Reporting and Learning Systems Report - 6 monthly
- External Reviews Report - Annually
- CQC Well-led Inspection report and actions
- Clinical Audit – Annually
- Litigation and Inquests – Annually
- Health & Safety – Annually

QGAC also received the Cancer Recover Plan, monthly, to inform its assessment of the BAF risk assigned to it.

In April 2020 the Committee agreed the draft Quality Account for the Trust. In November 2020 QGAC received a verbal report on the Trust Strategy and the development of strategic objectives for 2021/22. In March 2021 QGAC received a verbal report on the prioritisation of patients on waiting lists and how to reduce these in a fair and clinically justified way and asked that the criteria used be made public in an easy-to-understand way. QGAC was also concerned that those who chose not to go ahead with a procedure might be more vulnerable patients, less able to balance the risk from Covid-19 with the risk of not proceeding, and sought assurance that they did receive sufficient advice, and that an analysis would be carried out to see if such groups disproportionately declined treatment.

QGAC receives reports from the Chairs of the Compliance Oversight Group (COG) and the Quality Standards Improvement Group (QSIG), and the minutes of these meetings, which provide assurance through detailed reviews of compliance and risk. The chairs of QSIG and COG escalate to QGAC issues and assurances they obtain from the groups reporting to them. QSIG and COG normally meet each month, but during peak Covid-19 periods these meetings were suspended. QGAC did not receive their Chairs' reports at the meetings in April, May, January and February.

There are plans to merge COG and QSIG into a single committee which was intended to be completed by Autumn 2020. These have been delayed by Covid-19, but should take place during Summer 2021.

QGAC raised items to the Board from groups reporting to QSIG and COG concerning the following:
Alerts - Resuscitation Group Report - alert relating to audits of resuscitation trolleys, Medicines Management Group - alert relating to delayed antibiotic treatment for patients with sepsis, assure relating to overall management of medicines during Covid-19, Trust Safeguarding Group.
Advisories – National Laparotomy Audit, Cancer 104-day Harm reviews, Pleural Services Group Report, External Reviews Oversight Report, Learning from Experience Group, Equality, Diversity and Inclusion, Infection Prevention and Control.
Assurances - Quality Review Visits, Serious Untoward Incident Report, Radiation Safety Group, Audit of Duty of Candour Compliance, Organ Donation Group, End of Life (Swan) Group, Falls Prevention Group.

Board Assurance Framework (BAF) and Trust Risk Register (TRR)
The Committee monitored BAF risks SR12 - Mortality, SR13 - Cancer and SR14 – Covid-19 recovery. QGAC debated the definition of SR14 and the reformulation of SR13. During the year it was decided that SR12 could be removed from the BAF, as the target level for SHMI had been met and maintained.

The Committee monitors the Trust Risk Register and advised or alerted the Board regarding new risks or developments in risks as well as requesting improvements in the articulation of risks and questioning risk ratings and the need for some risks to continue on the TRR. The Committee was pleased to discuss drafts of the BAF and TRR Heat Map at its meetings in February and March, with a view to having a summary document which enables the meeting to assess the adequacy and completeness of the articulation of risks on the BAF and TRR as well as providing a useful quick reference for the Board.

Matters of note and assurance
Matters featuring in the Committee's reports to the Trust Board, included:
Matters of concern - during the year the Chair's report to the Board included -
Cancer performance and the impact of Covid-19 (April 20); suspension of harm review process and disruption to service (May); increase number of patients waiting over 104/62 days (June). Reduction in Breast screening, with 5000 patients waiting (October).

Suspension impact on elective operations from 11 January 21 due to Covid-19 pressures in order to secure enough staff for the required 200% increase in ICU beds (January 21). Drop in Breast Cancer referrals 2 week wait performance (19.74% in November, 6.25% in December) (January).

During Covid-19, the Committee noted the use of private sector providers for urgent cases the redeployment of staff from the theatres at Cannock to ICCU, the adverse impact on Cancer metrics with support sought from other Black Country Trusts (February 21). Restoration of pre-Covid-19 clinics and reductions in waiting times, use of Fast track clinics in line with normal levels; breast referral numbers the biggest concern with bookings at day 28 and 170 patients waiting over 14 days. Additional sessions working through the backlog of patients and additional support from one other Trust (March 21).

Other Covid-19 impacts - flow through Emergency Department resulting in long waits and delayed ambulance handovers due to need to keep patients segregated (November 20) with 364 Urgent care ambulance handover breaches over 60 minutes in December. Additional measures in place to address off-loading issues and required safety measures concentrating on flow and routing patients to the right ward to reflect their Covid-19 status (January 21).

Covid-19 impact on waiting lists: patients waiting for over 52 weeks for treatment were 10 in April (May 2020), 842 (November), 997 (December), 1443 (January 21) and 2054 in February (March 21). Covid-19 impact on Referral to Treatment - The number of patients waiting over 18 weeks deteriorated during February reaching 42,235 (target is below 40,000) due to the impact of Covid-19 related suspension of routine elective inpatients and outpatient clinics. (March 21)

Other Covid-19 and related matters - Medicines: storage, prescribing and use - deep and detailed review carried out in response to issues raised by CQC visit revealed significant issues with a comprehensive action plan (July 20). Shortage of reagents for Covid19 testing (September 20) escalated nationally. Mental Capacity Act and Deprivation of Liberty Safeguards Assessments: examples of MCA testing not implemented or documented and of omissions/absence of DoLS in some areas with actions to address (October 20). C-Section Rates: emergency C sections at 28% were higher than expected with a combined emergency and elective rate just under 40%.

Proportionately more women required intervention and subsequent C-section including those in premature labour and those seriously ill with COVID-19 (February 21). C sections reduced to 34% by March 21 as Covid-19 levels declined.

Stroke assessment within 24 hours percentage below target due to stroke patients being dispersed to other wards due to COVID-19 with assurances that patients continued to receive appropriate treatment within the 24-hour window. (February 21).

Black Country Pathology Service: Microbiology at Wolverhampton UKAS accreditation suspended following a virtual inspection with some significant issues including slippage of the audit plan. The assessment report received and action plans in place with review expected in May 21. The Board accepted the recommendation that the highlighted cultural and quality issues be covered in greater depth at a board development session. (March 21)

Clinical Audit: Audit activity was suspended across the Trust for Q1 and 2 2020/21 due to the COVID-19 pandemic and again in January 2021 to end of 2020/21. On 16 March 2020 NHSE confirmed that national audits and some national registries were also suspended with expected reduced levels of completion: 56% in Division 1, 37% Division 2, 35% Division 3. (March 21)

Never Events: unintentional connection of a patient requiring oxygen to an air flowmeter. Actions included reminder to all matrons of the three barriers that reduce the risk of oxygen tubing being connected to air flow meters and immediate review to ensure air flow meters are not in-situ unless explicitly required. (March 21)

Matters of assurance - during the year the Chair's report included the following -
Mortality: the Learning from Deaths Report and the Mortality Action Plan showed a wealth of actions being taken to improve care and the Trust's understanding of care pathways. This and the steadily reducing SHMI resulted in the Mortality BAF risk SR12 being removed (July 20).
Evidence of learning from deaths through sharing of knowledge gained through SJRs (October)
Information Governance: Trust submission that all conditions were met (September)
Audit of Duty of Candour showed very good levels of compliance in all divisions.
CQI Report showed work had continued including online training materials, development of Outpatient Futures, the Huddle Tool, and a single referral form in Community - staff's own initiative supported by the CQI team. (October)

Discharges: QGAC heard that excellent co-operation between the Trust and Wolverhampton Social Services had enabled patients to be discharged swiftly and safely, maintaining flow out of the hospital and freeing up beds. (March)

Matters of achievement - During the year the Chair's report included the following:
Quality Review Visits to South East District Nurses based at Bilston Health Centre - two domain good and 3 outstanding - and to Durnall Unit, September 2019 - all domains good, with Caring outstanding, and all actions implemented.

COG: Patient Experience Report: There has been considerable and increased volunteering activity, the Trust's success being reported on the national news relating to the recruitment of Community Clinical Volunteers.

Organ Donation: Despite all the difficulties of COVID, RWT's performance has been good, and from being in the bottom tier (tier 4) for performance in 2016 the trust is now in line to be in the top tier. (November)

Committee Non-executive Members
QGAC exchanges information with other Committees, for example agreeing to take on the follow-up of one of the Internal Audit reports (Radiography in the Radiotherapy Department) and passing on one issue concerning digital innovation to the Innovation Committee. The Chair of the QGAC attends the Audit Committee, which helps to maintain the flow of information between the committees, particularly on clinical audit matters.

Audit was informed of the self-assessment QGAC carried out (see below) covering, in particular, QGAC's role in monitoring clinical audit. The Healthcare Quality Improvement Partnership's publication Clinical Audit: a simple guide for NHS boards was used to review how clinical audit is managed, and the Medical Director will be considering with other stakeholders the way clinical audit can be redesigned to align more closely to the Trust's strategic objectives. A paper on this should come to QGAC in May 2021. One QGAC member is also on the Innovation Committee which assists the flow of information on digital health matters.

Self-assessment: QGAC members completed a self-assessment questionnaire based on an adaptation of a standard Audit Committee format. The results were provided to the September meeting. QGAC reviewed its TOR in April 2020 and March 2021 and received board approval. Deloittes observed the February 2021 meeting and the Company Secretary for Walsall Healthcare NHS Trust the meeting in March 2021.

Finance and Performance Committee

Committee M Martin, Chair, S Rawlings, J Hemans, J Dunn (from February 2021)

The aims of the Committee are to provide the Trust Board with assurance on the effective financial and external performance targets of the organisation. It also supports the development, implementation and delivery of the Medium-Term Financial Plan (MTFP) and the efficient use of financial resources in order to review the Trusts Financial strategy, performance and business development

The Committee met monthly and considered in detail:

- Trust's financial position
- Financial Recovery Board report which includes progress on the Cost Improvement Programme
- The progress of the capital programme
- Performance aspects of the Trust Board's quality and performance report.

It also considered

- Impact of Covid 19 on Performance
- Cancer Action Plan
- Group, Service Line Reporting
- Sustainability and Transformation Programme (STP)
- Contracting & Business Development Update
- Annual Budget/Income Expenditure Plan
- Cash Flow Report
- Temporary Staffing Dashboard
- Local Clinical Research Network (LCRN) finance report
- Procurement report
- 5 Year Capital Plan
- Backlog Maintenance Programme
- Other matters associated with operational finance and budgeting.

The non-exhaustive list is managed on an annual plan/cycle of work with upward reporting Groups and the Committee maintains an issues log to communicate issues for redress.

Matters of note and assurance
These matters featured in the Committee's reports to the Trust Board, including;

Matters of concern - During the year the Committee has noted the following matters of concern:
1) The potential impact of Covid-19 on the Trust's financial position and on performance.
2) The recovery plan for restoring services especially for cancer referrals
3) The agreement of the capital budget including Covis-19 related capital was not finalized until late in the financial year. The Trust achieved its CRL.

Matters of assurance - During the year the Committee has noted the following matters of assurance:
1) The cashflow management was considerably helped by the payments in advance and healthy cash balances were maintained
2) The EU transition meetings monitored the preparedness for leaving the EU and procurement did extensive work to secure the supply chains.
3) The full budget planning exercise was undertaken across the Trust for expenditure in 2021/22.

Matters of achievement - During the year the Committee has noted the following matters of achievement:
1) The continued high performance of the Clinical Research Network West Midlands. All non-essential clinical trials were paused and focus was on urgent public health Covis-19 studies.
2) The Babylon contract was reviewed in detail and recommended to the Board for approval

Committee Non-executive Members
The Chair of the Committee is a member of the Audit Committee, which helps to maintain the flow of information between the committees, particularly on financial risks.

Non-Executive Directors' attendances were recorded as being high during the year, and the Committee was quorate at each meeting.

Workforce & Organisational Development (WOD) Committee

Members: Chair: J Hemans, Members: R Dunshea + one 'floating' Member

Aims of the Committee
The purpose of the committee is to provide the Board with assurance that:
- The organisational development and workforce strategy, structures, systems and processes are in place and functioning to support employees in the provision and delivery of high quality, safe patient care
- Processes are in place to support optimum employee, engagement, wellbeing and performance to enable the delivery of strategy and business plans in line with the trust's values
- The Trust is meeting its legal and regulatory duties in relation to its employees
- Where there are human resource risks and issues that may jeopardise the Trusts ability to deliver its objectives, that these are being managed in a controlled way through the Trust Management Committee.
- The organisational culture is diagnosed and understood and actions are in place to ensure continuous improvements in culture.

To provide assurance on the following key areas of workforce governance:
- Resourcing and Skills
- Leadership & organisational effectiveness
- Engagement & Culture
- Wellbeing
- Productivity

Frequency of Meetings and Main Focus
During 2020-2021, the Committee met 6 times (bi-monthly).
At each meeting the Committee considered progress updates on:

- Executive Workforce Report including update from Model Hospital
- Workforce Resourcing & Productivity (including Retention)
- Employee Relations and Improving People Practices Update
- Staff Engagement and Surveys and Communications Agenda
- Education & Training & Apprenticeships & Leadership
- Equalities, Diversity & Inclusion
- Workforce Plan
- Health & Wellbeing
- Board Assurance Framework and
- Divisional Deep Dive Reviews

Activity
The Committee received and discussed reports on

- Executive Workforce Report
- Targets for 2020-2021
- Health and Wellbeing Support for Staff – During and Post COVID-19 Surge periods
- Board Assurance Framework
- Discussion on Anti-Discrimination
- Workforce Resourcing & Productivity (including retention)
- Employee Relations and Improving People Practices
- Education & Training, Apprenticeships and Leadership
- Equalities: WRES and WDES Data
- Division 1, 2 & 3 Deep Dive/Reviews
- Institute of Healthcare Management
- RWT Response to the National People Plan
- Equality, Diversity and Inclusion: BAME Update Report
- Staff Engagement & Survey and the Wider Communications Agenda
- Update on Job Planning Committee
- Reverse Mentoring
- Workforce Modelling and Planning
- Recruitment - Analysis Update Report
- Key Update - Staff Vaccination
- Review of Annual Planner 2021-2022 and Terms of Reference
- Workforce & Organisational Development Strategic Objectives (2021/22)
- Black Internship Programme
- Equality, Diversity & Inclusion Update
- Nurse Staffing During Covid Response
- Wellbeing Guardian
- Race Code
- 2020 Workforce Race Equality Standard (WRES) Report
- Risks Review / Assessment re Revised Strategic Objectives and Aims

The non-exhaustive list is managed on an annual plan/cycle of work with upward reporting Groups and the Committee maintains an issues log to communicate issues for redress.

The Committee also received regular reports from the Operational Workforce Group (OWG).

Matters of note and assurance

Matters of concern –
During the year the Committee has noted the following matters of concern:

4) Job Planning – need to have a full and regular update on the plans and progress on its implementation
5) Employee Voice Groups – offer to expand opportunity to include NEDs

Matters of assurance –
During the year the Committee has noted the following matters of assurance:

1) Recruitment - an understanding of where we recruit from
2) Workforce modelling & planning – need to develop an action plan
3) Equality, Diversity & Inclusion – more detailed plans to be reviewed
4) More extensive review on the wider attraction & retention agenda

Matters of achievement –
During the year the Committee has noted the following matters of achievement:

1. Armed Forces Employer Recognition Scheme – Gold Award
2. Implementation of e-job planning, e-leave & medical e-roster
3. Continued reduction in vacancy levels
4. Introduction of reverse/diversity mentoring
5. Black Internship Programme
6. Development of an EDI Delivery Plan
7. Establishment of Employee Voice Groups
8. Development of the Inclusive Recruitment Toolkit
9. Focus on the Wellbeing agenda, both pre and post Covid
10. Implementation of MH First Aiders
11. Development of Covid 19 risk assessments
12. Actions in relation to improving people practices
13. Review and implementation of workforce thresholds and targets
14. Establishment of the West Midlands Hub of the Institute Healthcare Management

Committee Non-executive Members
The Chair of the Committee is a member of the Finance & Performance, Remuneration and Clinical Ethics Committees, which helps to maintain the flow of information between the committees, particularly on finance and clinical audit matters.

The Committee Members (NEDs) have experience across, Audit Committee, Finance & Performance, Charity and Quality Governance Assurance Committees, that they bring to bear on the matter attended to at the Committee.

Non-Executive Directors' attendances were recorded as being high during the year, and the Committee was quorate at each meeting.

Remuneration Committee

Members: M Martin (Chair), S Field, R Edwards, J Hemans, S Rawlings

The purpose of this Committee is to advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors. The Remuneration Committee met several times during the year as required and has reviewed Executive Director Remuneration and appraised the performance of the Chief Executive (in his absence). The Chairman appraised all of the Non-Executive Directors and the Senior Independent Director (SID) appraised the Chairs performance.

Charitable Funds Committee

Members: S Rawlings (Chair), R Dunshea

The aim of the Committee is to administer the Trust's Charitable Funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.
During 2020/2021, the Committee continued to benefit from the dedicated support of an in-house Fundraising Coordinator and the Community and Events Fundraiser.

The Fundraising Team are ably supported by the Head of Communications and her team, as well as the on-going help of the Finance Team and external investment adviser. The refreshed newsletter and increased use of social media has raised further awareness of the charity and our work and enabled us to publicly thank our dedicated supporters for everything they have done to support our work over the last year.
A wide range of projects were supported during the year for the benefit of the welfare and comfort of our patients and staff as well as some capital items – going over and above that which can be provided by the Trust itself.

Trust Management Committee

Aims of the Committee

Chaired by the Chief Executive, the Trust Management Committee (TMC) provides a formal platform for the major decision-making process for clinical and non-clinical operations, and as such is not attended by Non-Executive Directors, but all of the Executives attend, along with Divisional Medical Directors and Heads of Service. High attendance rates were recorded at all of these meetings.

Frequency of meetings and main focus

During 2020-2021, the Committee met monthly except in August and December

Activity

The committee receives monthly reports from the Divisions on governance, nursing and quality issues, as well as business cases above a certain value. The Committee also receives monthly updates on finance, human resources, the capital programme, vertical integration, nursing and midwifery professional issues, policies, the Integrated Quality Performance Report (IQPR), and the Trust efficiency programme.

Quarterly updates are presented on cancer services, infection prevention, research and development, information governance and the integrated electronic patient record project. Reports on other matters, such as education and training, are also submitted periodically. During the year, the Committee started to include on its agendas a strategic matter for discussion, in order to engage the members in considering and debating together some of the bigger issues facing the organisation going forward.

It approves in line with Standing Financial Instructions, some Business Cases and all new or significantly changed Policies and Procedures. The non-exhaustive list is managed on an annual plan/cycle of work with upward reporting Groups and the Committee maintains an issues log to communicate issues for redress.

Matters of note and assurance

Matters of concern - During the year the Committee has noted the following matters of concern: COVID-19 and the impact on staff health and wellbeing and the local population it serves
Matters of assurance - Restoration and Recovery of Services
Matters of achievement - Becoming a Smoke Free Trust - 1 October 2020

Innovation, Research and Adoption Committee

Members: Professor A Pandyan, R Dunshea (Chair).

The aims of the Committee are to provide the Trust Board with an independent and objective review of the Trust's innovation and research aims and developments. This is a new committee and 2020-21 was its first full year of working.

Each meeting received reports from the executive and senior clinical leads on the initiation of strategic innovation development projects. Presentations were received on digital strategy, health informatics systems, artificial intelligence applications, Covid-19 research projects, and the establishment of an integrated care system for Wolverhampton. It also was briefed on the progress to set up the Institute of Health Innovation; a partnership with the University of Wolverhampton.

The committee had oversight of new contractual partnerships with Babylon Health and Sensyne Health. These are at early stage and the focus must now move to benefits realisation. The impact of the Covid-19 pandemic has been profound and has in many ways acted as a catalyst to improve services through the use of IT and related technologies. The committee was keen to ensure lessons have been learnt and long-term transformation achieved to improve patient outcomes.

The committee met five times during the year and was quorate. The contributions from a broad range of clinical and IT disciplines were greatly appreciated.

Clinical Ethics Committee

Members: Prof. L.Toner (Chair), Prof. S.Field, Mr J.Hemans (to March 2021)

The Committee was newly formed in (check) June 2020 and comprises a Non-Executive Chair and two NED members including the Trust Chair and a range of clinical professional staff from across the clinical professions and service areas. It has met on average every other month since with hiatus during Covid-19 waves due to clinical operational pressures.

The Committee has used the Oxford Ethox Clinical Ethics Committee materials and training information from its formation and early development. To date it has considered set case examples and one clinical example following the resolution of the case. It will continue its development in 2021 and 2022 with input from Clinical Ethics experts and access to external training and development opportunities

Freedom to speak up - concerns raised

The Royal Wolverhampton NHS Trust has been committed to its Freedom to Speak Up journey and the Guardian role since October 2016. The Trust Board have shown their full commitment and support to embed FTSU within the organisation as per national policy and requirements.

The Trust has been working with the Freedom to Speak Up (FTSU) Guardian to progress the below five identified FTSU objectives and has devised a Speak Up Vision. The objectives below have been successfully achieved and are evidenced in the FTSU Guardian Board reports.
Our objectives are;

1. Raise the profile and develop a culture where speaking up becomes normal practice to address concerns
2. Develop mechanisms to empower and encourage staff to speak up safely
3. Ensure that the Trust provides a safe environment for employees and others to raise concerns and speak up
4. Ensure that concerns are effectively investigated and the Trust acts on its findings
5. Ensure shared learning amongst local/regional/national Networks

Covid-19 & Speaking Up

Despite the challenges of Covid-19 the Guardian has worked with the organisation to provide the safest way to deliver FTSU support and has also offered support to the Contact Links (volunteer employees supporting FTSU). This year there has been an increase in the number of cases being reported to the Guardian, a good indicator of speaking up culture as evidenced in the most recent FTSU Trust Board report.

During the last unprecedented year, FTSU has focused on, online awareness training sessions and responded to departmental concerns. Training packages have been devised and delivered combining Equality, Diversity & Inclusion (EDI), Psychological Safety, and safe speaking up environments. This has been well received and has been successful due to the collaborative approach taken with the Trust EDI Lead, HR Advisory, Governance, Divisional, Departmental leads, and the Education & Training department.

FTSU Index Report

The National Guardian's Office (NGO), NHS England and Improvement have published a FTSU Index report since 2018. The report brings together four questions from the NHS Staff Survey that relate to whether staff feel knowledgeable, secure, and encouraged to speak up and whether they would be treated fairly after an incident. The FTSU Index seeks to allow trusts to see how an aspect of their FTSU culture compares with other organisations so learning can be shared, and improvements made (National Guardian Office: 2020).

The RWT FTSU Index Score has seen a positive increase year on year;
2018 77%
2019 78%
2020 78.4%

The 2019 FTSU Index score recorded a midrange position which was slightly lower than average at 78%. In 2020, this position has improved slightly to 78.4% however benchmarking data is currently not available. The Trust is showing improvements to its FTSU culture; further actions to embed FTSU within the organisation are required to ensure RWT achieve an above average FTSU Index score. The Guardian will work closely this next year with key stakeholders of the Trust to support actions in improving the FTSU Index score.

FTSU Data

Here is the Trust Freedom to Speak Up data recorded for the Financial year 2020/21 and reported to our Trust Board as well as our national requirement to report this data to the National Guardian Office; an independent non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes business as usual. The office is not a regulator, but is sponsored by the CQC, NHS England and Improvement.

Table 14

Figure 1: Total Number of FTSU cases reported to the National Guardian Office

2020/21	Total number of cases brought to Freedom to Speak Up Guardians, Champions and Ambassadors in your trust	#Cases raised anonymously	# of cases with an element of patient safety/quality	# of cases related to behaviours, including bullying/ harassment	# of cases where people indicate that they are suffering detriment as a result of speaking
Q1 2020/21	**22**	**1**	**4**	**16**	**2**
Q2 2020/21	**35**	**1**	**4**	**28**	**4**
*Q3 2020/21	**29**	**3**	**5**	**21**	**2**
Q4 2020/21	**27**	**3**	**6**	**20**	**4**

Freedom to Speak Up continues on its successful journey at The Royal Wolverhampton NHS Trust, and the collaborative approach has enabled quality interventions to take effect and improve the experience of staff and keeping our patients safe.

Capacity to handle risk

Risk Assessment

The Trust Board has approved a Risk Management Assurance Strategy which identifies that the Chief Executive has overall responsibility for risk management within the Trust. Within the strategy (and supporting policies) all managers and staff have delegated responsibility identified for the management of risk as part of their core duties. Training is provided to equip staff with appropriate knowledge and skills via a combination of e-training packages and handbook resources. A risk management e-training is available for senior managers and a separate package for all staff.

We manage risk through a series of processes that identifies risks, assesses their potential impact, and implements action to reduce/control that impact.

In practice this means:

- Interrogating internal sources of risk intelligence and activity to inform local and Trust level risk registers and assurance frameworks (e.g. incident, complaint, claim, audit, and compliance)
- Using committee / subgroup reporting to inform the risk registers
- Reviewing external / independent accounts of our performance to inform risk status (e.g. CQC standards, national benchmarks, external reviews and internal audit reports)
- Integrating functions (strategic and operational) at all levels of the Trust to feed a risk register and escalation process
- Using a standardised approach to risk reporting, grading and escalation. Our categorisation matrix supports a standard approach to risk tolerance
- Monitoring controls through positive and negative assurance and treatment actions for each risk, to mitigate and manage residual risks
- Developing and implementing a risk management and patient safety reporting policy (OP10) across the Trust
- Refinement of risk management training made available to all staff (including senior managers)

Management of the Risk Registers within the Trust

Risk registers are managed at the following levels:

- Divisional/Directorate/Departmental – operational risks that include clinical, business/service, financial, reputational, and patient/staff/stakeholders
- Trust Risk Register (TRR) – Any risks graded as 12 or above are escalated to the TRR for consideration by Directors. This has the purpose to inform Directors and the Trust Board of operational risks which may adversely impact the BAF and strategic objectives. Risks / elements of controls may also be delegated from the BAF to operational risk registers for management
- Board Assurance Framework (BAF) – Contains all risks which impact on our strategic objectives

Each risk on the BAF and TRR has an identified Director and operations lead to manage the risk.

The TRR and BAF were reviewed by Directors, the Board and management during 20/21at the following frequencies:

- QGAC – Monthly
- Trust Board – Bi Monthly
- Finance & Performance Committee - Monthly
- Delegated Committees – Monthly
- TMC review TRR – Monthly
- Divisional Governance - Monthly

During the year we have maintained focus on the quality of controls assigned to risks at all levels and the principles of measurable controls are applied. For risk registers to remain effective priority is also placed on the completion and update of assurances and actions to manage risk.

A total of 57 risks on the BAF and TRR were managed during the year 2020-2021, of these 21 were new risks identified in year. The 57 risks comprised of the following categories, 14 were red (red being the highest risk rating), 42 were amber, and 1 was yellow.

There were 20 new risks added onto the TRR in 20/21 including in the following areas (for example): Perfusion staffing, Prescribing & Administration of Critical Care Medicines in COVID-19, Safe and proper use of medicines, Number of registered nurses available who are trained to deliver Systemic Anti-Cancer Treatment (SACT), Looked After Children & Young People in Care, Cytology Pin Register, Room availability within the community setting for community midwives, Laboratory shortage of reagents for COVID-19 testing, Mental Capacity Assessment, Cardiothoracic surgical waiting list.

There was 1 new risk added onto the BAF in 20/21; SR14 - Trust services and reputation are adversely impacted upon by the medium to long term impacts of the Covid-19 outbreak.

There were 34 risks closed as at 31 March 2021, the remaining 23 to be carried forward to 2020/21.

There are two Red Risks on the Board Assurance Framework and three on Trust Risk Register (TRR) relating to Cancer performance metrics and the potentially adverse impact of the Covid-19 outbreak (BAF) and issues relating to review and communication of test results, Network support for Vascular Services and Consultant cover in Cancer Services (TRR).

The Risk and Control Framework

The Board-approved Risk Management Assurance Strategy includes the following:

- The aims and objectives for risk management in the organisation, aligned to our vision
- A description of the committee arrangements and relationships between various corporate committees and subgroups
- The BAF and process for management of risk registers
- The identification of the roles and responsibilities of all staff with regard to risk management, including accountability and reporting structures.
- The promotion of standard risk management systems as an integral part of assurance provision
- A description of the risk management process and a requirement for all risks to be recorded in a risk register prioritised (i.e. graded) and escalated using a standard scoring methodology

We seek to identify risks through all available intelligence sources including independent review, external review and assessment. The risk management process is supported by a number of policies which direct on risk assessment, incident reporting and investigation, mandatory training, health and safety, conflict resolution, violence and aggression, complaints, infection prevention, fire safety, human resources management, consent, manual handling and security. All policies have identified audit, monitoring and training arrangements.

The BAF identifies the risks to our strategic objectives, the key controls in place to manage these risks and the effectiveness of the controls shown in positive and negative assurance. The Internal Audit of the Board Assurance Framework (April 2020) reported significant assurance with 4 low and one improvement recommendation including that BAF reporting should make explicit the relationship between operational and strategic risks.

In addition, during 2020/21 the local (Trust initiated) audit of the Risk Management Strategy and Reporting Policy (OP10) showed good compliance with risk register reviews at all levels and sustained improvement with risk escalation/management.

All Committees of the Trust Board (excluding TMC) are chaired by Non-Executive Directors to reflect the need for independence and objectivity, ensuring that effective governance and controls are in place. This structure facilitates appropriate scrutiny and challenge of the performance of the organisation. The Committees met regularly throughout the year, and reported to the Trust Board following their meetings.

Risk management assurance - The trust annual Risk management audit concluded partial assurance with 2 low and 3 medium recommendations. The Trust takes a continuous improvement approach to its Risk Management arrangements and will action the recommendations and opinion of its internal auditors (Grant Thornton) to progress its Governance and risk management arrangements. The new divisional structure, now comprising three divisions has a well embedded reporting structure. The review of Governance infrastructure and functions for the Trust will reinforce and enhance a future for future Governance service.

Risk Management training - A Risk Management e-training package for senior managers and staff is made available on the Trust Intranet site. During the 1st and 2nd wave of Covid 19 compliance follow up of Risk management training was paused although remained available for staff that were able to complete the training.

During 2020/21 the Trust sustained improvement in the update of the TRR, aided by the set-up of a new monthly Risk Register Review Meeting. The timeliness of risk escalation to Trust TRR level has been a focus of the group and improvements made in year.

Assurance Priorities 2021/22
Review and align Quality assurance frameworks for QRV, Leadership Walkabouts and Quality audits
Implement systems and processes falling from the National Patient Safety Strategy
Embed the revised Quality reporting structure
Undertake an independent Well Led Review at the Trust

Challenges 2021/22
The Trust continues to progress its ambition to become an organisation providing an integrated care system. This will present new challenges as well as opportunities to streamline and evolve primary and secondary care pathways. A priority will also be to reinstate all service activity, reduce the backlog created by the Covid Pandemic and return to national target achievement.

As well as developing systems, processes and assurance structure, the trust also intends to demonstrate improvement. The enhancing of working links between Clinical Improvement Team and Governance and Risk Management team is key to this and will be complimented by the introduction of the new Patient Safety Specialist role.

Some of key achievements over the past 12 months are:
The Royal Wolverhampton NHS Trust continues to be rated ‘Good’ overall by the Care Quality Commission (CQC). During the Covid-19 Pandemic CQC adapted their inspection process to a Transitional Monitoring Approach (TMA), this involved telephone calls with organisations and reviewing a number of KLOE questions (Key Lines of Enquiry).

The Trust was engaged with three CQC TMA type calls relating to Emergency Department (ED), Infection Prevention (IP) and Well-Led. The feedback from CQC for ED and IP were of a good standard and the Trust is awaiting feedback from the Well-Led review.

Over the year various notifications were submitted to CQC relating to temporary closures in Primary Care, Urgent Treatment Centre due to COVID-19 and one change related to temporary appointment of nominated individual due to internal cover arrangements.

The Trust assesses ongoing CQC Compliance via Quality Review Visits (QRV) and lead assessment against the Fundamental standards of care, and self-assessment against Core Service frameworks.

The Trust has been unable to complete a full programme of quality review visits 2020/21 to assess ongoing compliance with Care Quality Commission (CQC) regulations due to the Covid-19 pandemic. Three QRVs have however been undertaken during this period. We are currently reviewing the QRV process going forward. An annual report on the 2020/21 quality review visit programme will be presented in May/June 2021. Further processes undertaken this year include confirm and challenge for key themed areas and CQC action plan monitoring of closed actions.

Compliance Summary

The Trust is fully compliant with the Self-assessment, declaration and registration requirements of the Care Quality Commission. 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 risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The Trust has recently approved a new 'Green Plan' bringing together all aspects of climate impact management.

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

The Trust has a robust governance structure in place ensuring monitoring and control of the effective and efficient use of the Trust's resources. Financial monitoring, service performance, quality and workforce information is scrutinised at meetings of the Trust Board, F&PC, TMC and at Divisional Team meetings.

The Trust has achieved all of its statutory financial targets, achieving an end of year surplus of £3.0m, delivering the Capital Programme within its Capital Resource Limit and achieving its External Funding Limit. The Trust has arrangements in place for setting objectives and targets on a strategic and annual basis. These arrangements include ensuring the financial strategy is affordable and scrutiny of cost savings plans to ensure achievement, with regular monitoring of performance against the plans.

This is done through:

- Approval of the annual budget by the Trust Board
- Monthly reporting to the Trust Board on key performance indicators covering finance, activity, governance, quality and performance
- Monthly reporting to the F&PC, Regular reporting at Operational and Divisional meetings on financial performance

- Finance Recovery Board meetings to oversee the Lord Carter economies work streams, and the Cost Improvement Programme

Internal Audit has provided assurance on internal controls, risk management and governance systems to the Audit Committee and to the Trust Board. Where scope for improvement in controls or value for money was identified during their review, appropriate recommendations were made and actions were agreed with management for implementation. The implementation of these actions is monitored by the Audit Committee

Information Governance & Data Security

SUMMARY OF SERIOUS INCIDENT REQUIRING INVESTIGATIONS INVOLVING PERSONAL DATA AS REPORTED TO THE INFORMATION COMMISSIONER'S OFFICE IN 2020/21

The table below details the incidents reported on the NHS Digital incident reporting tool and to the Information Commissioners Office (ICO), within the financial year 2020-2021. Any incidents that are still being investigated for the period 2020-21 are not included. The incidents listed below are for the Royal Wolverhampton NHS Trust and GP partnerships that have joined the Trust as listed below.

Table 15

Date incident occurred (Month)	Nature of incident	No. of data subjects	Description/ Nature of data involved	Further action on information risk
November 2020	Disclosed in error - email	10	A member of staff sent out a New Starter form via the recruitment system to at least 10 new starters. Unfortunately, the member of staff did not check the new starter form prior to attaching it to the system and the form was not blank, it contained sensitive personal information about an individual. They are aware that at least 3 of the recipients have read the email as they received phone calls from these individuals yesterday advising they had received it.	Contacted system provider to break the link in the email so individuals who had not opened the email prior to this could no longer see the email attachment. They also contacted all known recipients and asked to delete the email and situation was contained.
November 2020	Disclosed in error – email	1	Clinical letter for child 'A' was sent with details for child 'B'. Both children were being treated at the same clinic however information disclosed included the wrong diagnosis for child A.	Correct letters were sent to the relevant children's GPs/Children Hospital Consultants and advised to ignore the previous letter and confidentially destroy. Change in process with medical secretaries was implemented to ensure adequate checks are done on letters before being sent to patients and an audit was requested to ensure all letters sent around the same time were correct.
December 2020	Lost or Stolen Paperwork	40+	A member of staff who was planning on working from home, took blood request/referral forms home so they could book clinic appointments for the referrals. On their way home, their car was stolen with belongings, the blood request forms were among their belongings in the car. Blood forms contained name, address, sex, DOB, NHS Number and were all for glucose tolerance tests.	Car and its contents were not recovered. All patients were identified and were rebooked in for appointments so no delay on clinical care.

Table 16 Incidents classified at lower severity level

Incidents classified at severity level 1 are aggregated and provided in table below:

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS IN 2012-21		
Category	**Breach Type**	**Total**
A	Corruption or inability to recover electronic data	2
B	Disclosed in Error	85
C	Lost in Transit	3
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	7
F	Non-secure Disposal – hardware	0
G	Non-secure Disposal – paperwork	3
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	5
J	Unauthorised access/disclosure	8
		113

Data Protection and Security Toolkit Return 2019/ 2020 – final submission

Due to the current situation relating to Covid-19, NHS Digital (NHSD) recognises that it will be difficult for many organisations to fully complete the toolkit without impacting on their COVID-19 response. NHSD took the decision to push back the 2019/20 deadline for DSPT submission to 30 September 2020. The results for the final submission for 2019-20 for all are shown below.

The Royal Wolverhampton NHS Trust RL4 Standards Met

Alfred	M92002 Standards Met
West Park Surgery	M92042 Standards Met
Thornley Street	M92028 Standards Met
Lea Road	M92007 Standards Met
Penn Manor	M92011 Standards Met
Coalway Road	M92006 Standards Met
Warstones	M92044 Standards Met
Lakeside	M83132 Standards Met
Dr Bilas Surgery	M92026 Standards Met

Looking forward to 2020/21 Data Security and Protection (DSP)

Due to the current Covid-19 response the DSP Toolkit (DSPT) for 2020-21 will not be submitted until June 2021, in line with the newly set date by NHS Digital. The Trust will continue to work towards achieving compliance with the DSPT which will be published later this year. An internal audit of the DSPT in November 2020 had provided significant assurance of the processes and evidence that is in place to support the DSPT submission.

The Trust continues to monitor patterns and trends of data security incidents and implementing measures to reduce these to the lowest level practicable. Current risks include the increasing risk of external threats in relation to Cyber security, such as particularly email ‘phishing’. Other risks to data security include - disclosure in error due to increased remote working during the Covid period.

Work continues to improve controls and practices to manage these risks. The Trust has continued to embed the requirements of the General Data Protection Regulation 2016 (GDPR) into day to day practices, monitored via a variety of groups. This is to ensure that data privacy is at the forefront of the care that we provide and the information that is captured.

The Trust remains focused on embedding principles of privacy by design into Trust processes, from procurement to digital innovation and service redesign. This program of work is monitored though the committee structure.

- The Trust has several committees dedicated to reviewing assurance in relation to DSPT and GDPR, chaired by senior Board members.
- The Chief Medical Officer is the Trust's trained Caldicott guardian, and is responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. The Guardian plays a key role in ensuring that Trust satisfies the highest practical standards for handling patient identifiable information, and Chairs the Information Governance (IG) Steering group and GDPR implementation group.
- The Chief Financial Officer is the Trust's Senior Information Risk Officer (SIRO) and is responsible for monitoring the Trust's overall information risk, ensuring we have a robust incident reporting process for information risks. The SIRO reports to the Trust Board and provides advice on the matter of information risk. The SIRO is also a member of the IG Steering Group and co-chair of the GDPR implementation group.
- The Trust has an assigned Data Protection Officer (DPO) who acts independently to ensure compliance with the GDPR as well as monitoring its application across the Trust. The DPO has a reporting line into the Caldicott Guardian through to the Trust board.
- The Trust is in the process of implementation a robust asset management system and defining establishing clear responsibilities for Information Asset Owners (IAO) across the Trust to facilitate robust and timely escalation of information risk escalation to the SIRO.
- Regular reports are provided to the Trust Board during the year to ensure that they are sighted on and support the Trust's plans in relation to data security and protection. To support this each toolkit assertion is aligned to a director responsible on the board.
- All Trust board members received NHSD approved cyber and data security training, and will receive updates and briefings in relation to the Trust performance in this area.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Guidance for Quality Accounts remains in place nationally, which outlines the requirements with respect of the format, content and reporting arrangements for the annual Quality Accounts. The Trust used this guidance to ensure that its requirements were included in the Trust's Quality Account 2020-2021.

The Trust's quality priorities for 2020-2021 were selected as part of a consultation process with our staff and external stakeholders. In addition, the Trust reviewed what patients and members of the public said about us through national and local surveys, in-patient feedback received through complaints, compliments and the Friends and Family Test. In addition, various national and local guidance and feedback from the Care Quality Commission were considered.

The Quality Account outlines the progress made against the 2020-2021 objectives together with details of the key objectives for the forthcoming year. These objectives have been set based on the priorities of the Trust, considering external accreditation, variety of surveys, CQC inspection outcomes, key improvement priorities and views of the staff, patients, public and our key stakeholders.

The following information has been included in the Quality Account as per the 2020-2021 requirement outlined in the letter received by NHS England and Improvement in January 2020:

- A statement regarding progress in implementing the priority clinical standards for seven-day hospital services.
- In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS trusts and NHS foundation trusts in England to report annually on staff who speak up (including whistle-blowers). Ahead of such legislation, NHS trusts and NHS foundation trusts are asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment. This disclosure should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the trust.
- Organisations have also been reminded that schedule 6, paragraph 11b of the *Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016* requires "a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the Trust's Quality Account".
- Despite the assurance audit being ceased for the 2019/20 Quality Account, updates against the actions agreed following the last year's audit have been provided.
- The draft Quality Account shared internally contains information relating to the National Inpatient Survey results for 2020. However, these results are currently embargoed and as such cannot be shared externally.
- Final data is awaited for a number of data sets, which will be included in the final version of the Quality Account.

Note:

The Quality Account was to be published by no later than 30th June 2020 and as a result, the final version presented to Trust Board on 2nd June 2020. However, please note the caveat with regards to the National Inpatient Survey 2019. In addition, NHS England and Improvement have indicated that due to the significant pressures associated with Covid-19 (coronavirus) pandemic, the publication date has been deferred to later in the year. However, RWT has kept to the original plan timescales

Operational Performance

The Trust is committed to delivering the national requirements and operational performance standards. These are robustly monitored and managed to ensure patients receive the most appropriate levels of care. A comprehensive performance management process exists across the Trust to monitor delivery against these standards alongside trust wide organisational efficiently metrics and other quality-based indicators of effective standards of care.

The framework we employ is multi-faceted and covers many levels across the organisation. This includes weekly review at the Chief Operating Officer's performance meeting and through subsequent meetings across the Divisions. A detailed Integrated Quality and Performance Report (IQPR) is produced monthly; performance is discussed in-depth at the monthly Finance and Performance Committee, which is chaired by a Non-executive Director, with further scrutiny taking place at the full Trust Board. These have continued to be produced, reviewed and monitored throughout the impact of the Covid-19 pandemic.

Emergency Planning / Resilience

The Emergency Preparedness, Resilience and Response (EPRR) agenda has dominated NHS organisations in 2020/2021. This is a collective result of COVID-19 response command structures, and the management of several concurrent risks and incidents including, the end of EU Transition Period and influenza.

COVID-19 is a realisation of the highest scored item on the UK Government National Risk Register – Pandemic. However, the root cause infection was not the long-anticipated influenza pandemic, but a novel corona virus. The virus continues to present NHS Providers with substantial clinical challenges in its treatment and containment, including the supply and safe use of personal protective equipment and demand for critical care services.

The Trust already has a well-established, command and control structure in place; which is effectively being used, and has been since the start of the Trust's response to COVID-19. The Trust's Incident Control Centre (ICC) has been operating 7 days a week since March 2020.

As part of COVID-19 infectious disease outbreak, as part of the ongoing response to this civil emergency, the Trust is working in collaboration with the local health care economy through formal standing meetings and ad hoc arrangements. Emergency planning arrangements have been invoked. This includes being involved in multi-agency command structures to co-ordinate key areas of focus, manage risks and support timely decision making and responding to the many national countermeasures.

Due to the pressures presented by COVID-19, business continuity management has been evoked, as planned staffing remains under pressure and supply chain of essential equipment has at times been tested to the extreme. A COVID-19 email box was established and is still in situ and monitored by Emergency Planning to manage the flow of information, supported by a series of subject matter experts who receive requests and respond.

The Trust has established plans in place supported by service continuity plans, with further updates being planned for. It should be noted that a number of training, exercises and testing events have been cancelled due to the COVID-19 response. The Trust events will be rescheduled at an appropriate time.

Other activities have been undertaken to improve emergency preparedness response for the Trust; development of a Trust induction DVD on emergency preparedness for all staff, improvement of EPRR intranet site and the development of an electronic grab pack for Strategic and Tactical commanders to use in the event of responding to an emergency incident.

EU Exit. From the 1 February 2020 the UK entered into a transition period which started the withdrawal process from the EU until the 31 December 2020. Due to the many different EPRR steams the NHS adopted a single operational response model to respond to the EU Exit, COVID-19 and winter pressures. The EU Exit transition period has now ended with nil impact reported to the Trust to date. However, the Trust has continued to maintain its current level of preparedness in case of potential further impacts on service delivery over coming months.

EPRR Assurance. The assurance process changed slightly due to COVID-19. The Trust in 2019/2020 EPRR Core Standards self-assessment achieved a Fully Compliant status, these are continually under review.

The Trust has responded well to the many challenges that have been presented and continues to improve its response, COVID-19 being the biggest challenge.

An Emergency Preparedness Response & Resilience Annual Report has been produced identifying the Trust's resilience and key priorities for the forthcoming year.

Health and Safety at Work

The Trust Health and Safety risk profile has been maintained and shows compliance with relevant Health and Safety Executive (HSE) legislation. Work continues to identify gaps and provide action plans to fill these gaps giving the Board an improved assurance around compliance with the Regulations. Estates and Facilities continue to work towards compliance with the Premises Assurance Model (PAM) accreditation system, this is adding to the robustness of assurance received from Estates.

During 2020/21 there has been a focus on ensuring Covid Safe risk assessments are in place for staff who continue to work on site, and this will continue into 2021/22 as more staff return to work.

There has been an 18.1% reduction in the number of health and safety incidents when comparing 2019/20 to 2020/21. Total incidents reduced from 597 in 2029/20 to 489 in 2020/21. Focus has remained on the high incident reporting areas; ensuring investigations are undertaken where needed and risk assessments reviewed to improve control measures. Emphasis continues on sharing lessons identified across the Trust, using various forums, including the Safety Representative Forum, and our Risk Newsletter 'Risky Business' and direct email depending which method is felt most suitable at the time.

The top 5 reported health and safety related incidents for the year are:

Category	19/20	20/21	DoT
Slips, trips & falls - Staff	197	147	↑
Sharps injury	196	179	↑
Contact	122	74	↑
Manual handling activity	80	91	→
Hazardous substances	59	64	→

An additional category to highlight which has shown a deterioration is Occupational Health:

Category	19/20	20/21	DoT
Occupational health	21	72	↓

Occupational health incidents for this reporting period.

- Face mask irritations/allergy
- Potential outbreaks of Covid 19

Social Economic Responsibilities: Modern Slavery and Forced Labour

The Trust sources its procurement function the Integrated Supplies & Procurement Department (ISPD) based at University Hospitals North Midlands which is committed to:

- Utilise the Sustainable Procurement Flexible Framework (SPFF) to facilitate the procurement of goods and services in a more innovative, sustainable manner. This self-assessment mechanism allows each Trust to measure and monitor progress on sustainable procurement over time. All Trusts are aiming for year on year improvements to achieve and work through the actions in the SPFF, working through the levels from Foundation Level 1 to achieve Lead Level 5 by 2021-22.

- Purchase more goods from sustainable sources, with a focus on those from local, ethical and Fair-Trade Suppliers, reducing carbon emissions and improving labour standards are very important areas for the health and social care sector as a whole. All Trusts have an ethical duty to protect and promote health and wellbeing and contract with suppliers of goods and services that operate in a socially responsible way with good environmental practices and employment practices.

The Trusts will use Ethical Procurement for Health (EPH) to support this. Products used will have sustainable specifications using Government Buying standards and Green Public Procurement criteria. The Trusts aim to use their buying power to generate social benefits and consider economic, social and environmental wellbeing when negotiating public service contracts as enshrined in the Public Services (Social Value) Act 2012.

In addition, the NHS Terms & Conditions of Contract for goods & services specify the following terms for suppliers to adhere to in relation to Equality & Human Rights:

- Ensure that (a) it does not, whether as employer or as provider of the Services, engage in any act or omission that would contravene the Equality Legislation, and (b) it complies with all its obligations as an employer or provider of the Services as set out in the Equality Legislation and take reasonable endeavours to ensure its Staff do not unlawfully discriminate within the meaning of the Equality Legislation;

- in the management of its affairs and the development of its equality and diversity policies, cooperate with the Authority in light of the Authority's obligations to comply with its statutory equality duties whether under the Equality Act 2010 or otherwise. The Supplier shall take such reasonable and proportionate steps as the Authority considers appropriate to promote equality and diversity, including race equality, equality of opportunity for disabled people, gender equality, and equality relating to religion and belief, sexual orientation and age; and the Supplier shall impose on all its Sub-contractors and suppliers, obligations substantially similar to those imposed on the Supplier.

Annual Declarations

1. The Royal Wolverhampton NHS Trust is required to register with the CQC and its current registration status is active. The Royal Wolverhampton NHS Trust has no conditions with its continued registration.
2. The CQC has not taken enforcement action against The Royal Wolverhampton NHS Trust during 2020/21.
3. The Trust has published through a link 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.
4. 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.
5. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.
6. The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.
7. The Trust made its annual self-assessment submission to the Department of Health as per the revised required timescales of the Information Governance Toolkit. (see Data Protection and security Toolkit Return section of this report).

Head of Internal Audit Opinion

"Our overall opinion for the period 1 April 2020 to 31 March 2021 is that based on the scope of reviews undertaken and the sample tests completed during the period, Significant assurance with some improvement required can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The level of non-compliance in certain areas puts some system objectives at risk. We identified weaknesses which put system objectives at risk in relation to the Primary Care Governance, Continuous Quality Improvement, the Allocate system and Consultant Job Planning. Otherwise, there are only minor weaknesses in the risk management activities and controls designed to achieve the risk management objectives required by management. Those activities and controls that we examined were operating with sufficient effectiveness to provide reasonable assurance that the related risk management objectives were achieved during the period under review."

Review of effectiveness of Risk Management and Internal Control

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 committee and governance & quality committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is informed by reports from external inspecting bodies including external audit and the Patient-Led Assessments of the Care Environment (PLACE) inspections (the system for assessing the quality of the patient environment). It is also informed by comments made by the External Auditors in their report to those charged with governance (ISA 260) and other reports. I have been advised on the implications of the result of my review of effectiveness of the system of internal control by the Trust Board, the Audit Committee, and the QGAC and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board has continued to undertake regular Development meetings throughout the year and has recently commenced a review to inform future Board development. It has monitored the performance and effectiveness of the Trust Board Committee's including the Audit Committee, Finance and Performance Committee, the Quality Governance Assurance Committee and the Workforce and Organisational Development Committee all of which have key roles in the assessment of assurance and effectiveness of the Trust and in the identification of and mitigation of any identified risks.

The Audit Committee has managed on behalf of the Trust Board the agreed programme of Audit including internal audit, external audit and clinical audit (alongside the Quality Governance Assurance Committee). The Board receives the presentation of examples of clinical audit work.

In relation to the Well-led Framework - the Trust undertakes continuous monitoring and self-assessment against the framework alongside the outcomes of inspections.

I have not identified any significant internal control issues or gaps in control from the work and assurances provided to me and to the Trust Board.

10. Conclusion

No significant internal control issues have been identified during 2020/21.

Accountable Officer: Prof. David Loughton CBE
Organisation: The Royal Wolverhampton NHS Trust,
Date: 9 June 2021

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	**588,601**	549,223
Other operating income	4	**154,684**	126,891
Operating expenses	6, 8	**(734,130)**	(656,732)
Operating surplus/(deficit) from continuing operations		**9,155**	19,382
Finance income	11	**26**	186
Finance expenses	12	**(2,105)**	(2,126)
PDC dividends payable		**(10,003)**	(10,589)
Net finance costs		**(12,082)**	(12,529)
Other gains / (losses)	13	**34**	53
Surplus / (deficit) for the year from continuing operations		**(2,893)**	6,906
Surplus / (deficit) for the year		**(2,893)**	6,906
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	17	**12,488**	3,561
May be reclassified to income and expenditure when certain conditions are met:			
Total comprehensive income / (expense) for the period		**9,595**	10,467
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		**(2,893)**	6,906
Remove net impairments not scoring to the Departmental expenditure limit		**5,658**	(1,408)
Remove I&E impact of capital grants and donations		**(1,709)**	156
Remove 2018/19 post audit PSF reallocation (2019/20 only)		**0**	(511)
Remove net impact of inventories received from DHSC group bodies for COVID response		**(813)**	0
Adjusted financial performance surplus / (deficit)		**243**	5,143

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	14	**5,526**	2,609
Property, plant and equipment	15	**382,916**	348,384
Receivables	19	**7,326**	6,532
Total non-current assets		**395,768**	357,525
Current assets			
Inventories	18	**8,802**	6,901
Receivables	19	**29,136**	60,820
Cash and cash equivalents	20	**54,351**	12,045
Total current assets		**92,289**	79,766
Current liabilities			
Trade and other payables	21	**(79,979)**	(68,910)
Borrowings	23	**(2,012)**	(2,032)
Provisions	25	**(4,592)**	(5,084)
Other liabilities	22	**(3,659)**	(3,300)
Total current liabilities		**(90,242)**	(79,326)
Total assets less current liabilities		**397,815**	357,965
Non-current liabilities			
Trade and other payables	21	**(58)**	(68)
Borrowings	23	**(5,576)**	(7,223)
Provisions	25	**(2,399)**	(1,859)
Total non-current liabilities		**(8,033)**	(9,150)
Total assets employed		**389,782**	348,815
Financed by			
Public dividend capital		**282,017**	250,646
Revaluation reserve		**76,872**	64,384
Other reserves		**190**	190
Income and expenditure reserve		**30,703**	33,595
Total taxpayers' equity		**389,782**	348,815

The notes on pages 44 to 77 form part of these accounts.

Name David Loughton
Position Chief Executive
Date 9 June 2021

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**250,646**	**64,384**	**190**	**33,595**	**348,815**
Surplus/(deficit) for the year	**0**	**0**	**0**	**(2,893)**	**(2,893)**
Revaluations	**0**	**12,488**	**0**	**0**	**12,488**
Public dividend capital received	**31,371**	**0**	**0**	**0**	**31,371**
Taxpayers' and others' equity at 31 March 2021	**282,017**	**76,872**	**190**	**30,703**	**389,782**

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	237,185	60,892	190	26,621	324,888
Taxpayers' and others' equity at 1 April 2019 - restated	237,185	60,892	190	26,621	324,888
Surplus/(deficit) for the year	0	0	0	6,906	6,906
Revaluations	0	3,561	0	0	3,561
Transfer to retained earnings on disposal of assets	0	(69)	0	69	0
Public dividend capital received	13,461	0	0	0	13,461
Taxpayers' and others' equity at 31 March 2020	250,646	64,384	190	33,595	348,815

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 and Social Care 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 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		**9,155**	19,382
Non-cash income and expense:			
Depreciation and amortisation	6.1	**21,230**	20,508
Net impairments	7	**5,658**	(1,327)
Income recognised in respect of capital donations	4	**(1,949)**	(102)
(Increase) / decrease in receivables and other assets		**31,355**	(26,314)
(Increase) / decrease in inventories		**(1,901)**	(294)
Increase / (decrease) in payables and other liabilities		**4,946**	14,826
Increase / (decrease) in provisions		**54**	1,792
Net cash flows from / (used in) operating activities		**68,548**	28,471
Cash flows from investing activities			
Interest received		**26**	186
Purchase of intangible assets		**(3,681)**	(646)
Purchase of PPE and investment property		**(39,784)**	(31,223)
Sales of PPE and investment property		**34**	53
Receipt of cash donations to purchase assets		**179**	102
Net cash flows from / (used in) investing activities		**(43,226)**	(31,528)
Cash flows from financing activities			
Public dividend capital received		**31,371**	13,461
Capital element of finance lease rental payments		**(211)**	(165)
Capital element of PFI, LIFT and other service concession payments		**(1,836)**	(1,818)
Interest paid on finance lease liabilities		**(16)**	(13)
Interest paid on PFI, LIFT and other service concession obligations		**(2,094)**	(2,116)
PDC dividend (paid) / refunded		**(10,230)**	(10,234)
Net cash flows from / (used in) financing activities		**16,984**	(885)
Increase / (decrease) in cash and cash equivalents		**42,306**	(3,942)
Cash and cash equivalents at 1 April - brought forward		**12,045**	15,987
Cash and cash equivalents at 1 April - restated		**12,045**	15,987
Cash and cash equivalents at 31 March	20.1	**54,351**	12,045

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 to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

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.

The Trust has prepared its financial plans and cash flow forecasts for the coming year on the assumption that funding will be received from the Department of Health and Social Care consistent with the revised funding arrangements in response to the COVID-19 pandemic. Discussions to date indicate this funding will be forthcoming. These funds are expected to be sufficient to enable the Trust to meet its obligations as they fall due and will be accessed through the nationally agreed process published by NHS Improvement and the Department of Health and Social Care.

The Board of Directors has therefore concluded that these financial statements should be prepared on a going concern basis as there is a reasonable expectation that the Trust will have adequate resources to continue in operational existence for at least 12 months from the date of approval of the financial statements.

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.

The main source of income for the Trust is contracts with commissioners in respect of health care services. The timing of the satisfaction of performance obligations is in line with typical timing of payment (i.e. 14-30 days dependant on credit terms agreed with customer).

Revenue from NHS contracts
The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21
The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Sustainability and Transformation Partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)
In the comparative period (2019/20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.
Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.
The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end this portion of revenue is deferred as a contract liability.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract. CQUIN payments are recognised when there is a high probability that income will not be reversed.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

For 2020/21 and 2019/20

Revenue from research contracts
Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.
The NHS Trust receives income from the National Institute for Health Research (NIHR) for the hosting of the Greater Midlands Clinical Research Network, which comprises the majority of the Trust's Research and Development Income.

NHS injury cost recovery scheme
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

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 employer, 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 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.

Local Government Pension Scheme
Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

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 Discontinued operations
Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.

Note 1.8 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 and individually have cost of more than £250, 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 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.

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.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the

decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit is to be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

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 have 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.

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

In 2020/21 this includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Components of the asset replaced by the operator during the contract, 'lifecycle replacement', are measured and capitalised at the time they are provided by the operator at their fair value where they meet the NHS Trust's criteria for capital expenditure.

The element of the annual unitary payment allocated to lifecycle replacement is predetermined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

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 life Years
Buildings, excluding dwellings	2	69
Dwellings	5	30
Plant & machinery	1	15
Transport equipment	5	7
Information technology	4	5
Furniture & fittings	9	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 1.9 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 when 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.

Useful lives of intangible assets
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 life Years
Software licences	4	5

Note 1.10 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.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.11 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 1.12 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.

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.

I**mpairment 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).

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' require an allowance for an expected credit loss. Lifetime credit losses are recognised if there is objective evidence of impairment as a result of one or more events that occurred after initial recognition of the asset and that have an impact on the estimated future cash flows of the asset. However, NHS bodies are not allowed to recognise any impairments against intra-DHSC balances as it is expected that they will be recoverable, therefore no lifetime credit losses are made against NHS bodies.

When estimating lifetime credit losses in relation to Injury Cost Recovery (ICR) receivables, the GAM instructs the Trust to include an amount within the credit loss allowances for contract receivables to reflect income that is not expected to be recoverable. Each year, the Compensation Recovery Unit (CRU) advises a percentage probability of not receiving the income. For 2020/21 this is 22.43% (2019/20 21.79%).

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 1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as a lessee
Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property, plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the Statement of Financial Position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as a lessor
Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.
Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.14 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	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.18%
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 2021:

	Inflation rate
Year 1	1.20%
Year 2	1.60%
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 25.2 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 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 26 unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:
• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 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 in the PDC dividend policy issued 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 1.17 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 1.18 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.19 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.20 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 FReM.

Note 1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.22 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.23 Transfers of functions from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

Note 1.23 Early adoption of standards, amendments and interpretations

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

Note 1.24 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 a rate 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. 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 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 expect this standard to have a material impact on non-current assets, liabilities and depreciation.
The Trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 Statement of Financial Position	
Additional right of use assets recognised for existing operating leases	4,397
Additional lease obligations recognised for existing operating leases	(3,840)
Net impact on net assets on 1 April 2022	**557**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(2,016)
Additional finance costs on lease liabilities	(55)
Lease rentals no longer charged to operating expenditure	1,974
Estimated impact on surplus / deficit in 2022/23	**(97)**
Estimated increase in capital additions for new leases commencing in 2022/23	**1,774**

In the estimates above the following discount rates have been applied: HM Treasury incremental borrowing rate (a nominal rate) of 0.91% is to be applied for leases commencing in the 2021 calendar year under IFRS 16. For leases commencing in the 2020 calendar year the incremental borrowing rate is 1.27%.

IFRS 17 Insurance Contracts
Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted. This would be applicable from 1st April 2023.and replaces IFRS 4 Insurance Contracts on accounting for insurance contracts. This standard is expected to have no material impact on the Trusts' financial statements.

Note 1.25 Critical judgements in applying accounting policies

In the application of the NHS Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

-Leases
The Trust applies the tests contained in IAS17 to all of its present and proposed leases in order to ascertain if they should be classed as operating or finance leases. Often the information available may be inconclusive and therefore judgement is made regarding the transfer of the risks and rewards of ownership of the associated assets in order that a decision may be made.

Note 1.26 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

-Useful Economic Lives
The Trust exercises judgement to determine the Useful Lives and residual values of property, plant and equipment and computer software. Depreciation and amortisation is provided so as to write down the value of these assets to their residual value over their estimated Useful Lives. Every care is taken to ensure that estimates are robust however factors such as unforeseen obsolescence or breakdown may impact on the actual life of the asset held.

-Provisions
When considering Provisions for events such as pension payments, NHS Resolution claims and other legal cases the Trust uses estimates based on expert advice from agencies such as NHS Resolution, legal advice from Trust advisors and the experience of its managers.

-Valuation of Non-Current Assets
The fair value of land and buildings is determined by valuations carried out by a Professional Valuer GVA Grimley Limited trading as Avison Young. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and Social Care and HM Treasury. A full valuation (excluding assets under construction/work in progress) was carried out as at 31 March 2021 and assets lives were also reviewed by GVA Grimley Limited trading as Avison Young as at this date. This valuation was based on published data from the Building Cost Information Service (BCIS) which provides a level of consistency in reporting and forecasting future trends. The valuation and the associated data was based on all in forecast Tender Price Index (TPI) as at 31 March 2021. Future revaluations of the Trust's property may result in further material changes to the carrying value of non-current assets.

Note 2 Operating Segments

Operating segments are reported in a manner consistent with the internal reporting provided to the Chief Operating Decision Maker. The Chief Operating Decision Maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Trust Board that makes strategic decisions.

The Trust has identified two operating segments:-

Healthcare Services

This is the core activity of the Trust. It is primarily the provision of NHS Healthcare services to patients, paid for by the relevant NHS Commissioner. Income for this segment is disaggregated in Note 3.1 and Note 4 except for Research and Development which includes Clinical Research Network to which the proportion relating to Clinical Research Network within Research and Development is shown in this Note.

Clinical Research Network

The Trust hosts the Greater Midlands Clinical Research Network, which has a separate Chief Operating Officer and is separately accounted for, so is an operating segment for the Trust. It receives funds from the National Institute for Health Research and pays for research provided by 29 NHS Trusts (including this Trust) plus 3 Universities. The total income for the Network is c.£28m. The Network operates on a break even basis. Income for this segment derives from Research and Development (contract) as disclosed in Note 4 of the accounts.

		Healthcare Services		**Clinical Research Network: West Midlands**		**Total**	
		2020/21	2019/20	**2020/21**	2019/20	**2020/21**	2019/20
		£000	£000	**£000**	£000	**£000**	£000
Income		**715,316**	649,200	**27,969**	26,914	**743,285**	676,114
Surplus/(Deficit)							
	Segment surplus/(deficit)	**(2,079)**	(1,940)	**0**	0	**(2,079)**	(1,940)
	Common costs	**(716,130)**	(640,354)	**(27,969)**	(26,914)	**(744,099)**	(667,268)
Surplus/(Deficit)		**(2,893)**	6,906	**0**	0	**(2,893)**	6,906
Net Assets:							
	Segment net assets	**389,839**	348,815	**0**	0	**389,839**	348,815

All assets & liabilities are reported to the Trust Board at a consolidated level so it is not possible to separate these by segment.

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 (Restated)	2019/20
	£000	£000	£000
Acute services			
Block contract / system envelope income*	**456,878**	419,041	311,080
High cost drugs income from commissioners (excluding pass-through costs)	**46,707**	46,330	46,330
Other NHS clinical income	**1,389**	1,574	109,535
Community services			
Block contract / system envelope income*	**44,545**	43,332	43,332
Income from other sources (e.g. local authorities)	**7,844**	8,033	8,033
All services			
Private patient income	**220**	1,020	1,020
Additional pension contribution central funding**	**17,865**	16,555	16,555
Other clinical income	**13,153**	13,338	13,338
Total income from activities	**588,601**	549,223	549,223

*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	**147,630**	147,919
Clinical commissioning groups	**420,755**	380,927
Other NHS providers	**1,389**	1,574
NHS other	**380**	342
Local authorities	**7,844**	8,619
Non-NHS: private patients	**220**	1,020
Non-NHS: overseas patients (chargeable to patient)	**376**	260
Injury cost recovery scheme	**610**	1,418
Non NHS: other	**9,397**	7,144
Total income from activities	**588,601**	549,223
Of which:		
Related to continuing operations	**588,601**	549,223

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2020/21	2019/20
	£000	£000
Income recognised this year	**376**	260
Cash payments received in-year	**43**	132
Amounts added to provision for impairment of receivables	**311**	(27)
Amounts written off in-year	**34**	16

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
Research and development	**28,297**	**0**	**28,297**	29,671	0	29,671
Education and training	**19,366**	**737**	**20,103**	16,639	721	17,360
Non-patient care services to other bodies	**45,029**	**0**	**45,029**	44,159	0	44,159
Provider sustainability fund (2019/20 only)	**0**	**0**	**0**	7,957	0	7,957
Marginal rate emergency tariff funding (2019/20 only)	**0**	**0**	**0**	2,254	0	2,254
Reimbursement and top up funding	**30,980**	**0**	**30,980**	0	0	0
Income in respect of employee benefits accounted on a gross basis	**5,246**	**0**	**5,246**	6,185	0	6,185
Receipt of capital grants and donations	**0**	**1,949**	**1,949**	0	102	102
Charitable and other contributions to expenditure***	**0**	**12,457**	**12,457**	0	0	0
Support from the Department of Health and Social Care for mergers**	**0**	**3,000**	**3,000**	0	6,000	6,000
Rental revenue from operating leases	**0**	**745**	**745**	0	922	922
Other income*	**6,878**	**0**	**6,878**	12,281	0	12,281
Total other operating income	**135,796**	**18,888**	**154,684**	119,146	7,745	126,891
Of which:						
Related to continuing operations			**154,684**			126,891

* Other contract income includes car parking income, catering income, pharmacy sales, staff accommodation rental and other income generation schemes (recognised under IFRS 15).

** Support from Department of Health and Social Care for mergers relates to income received following the dissolution of Mid-Staffordshire NHS Foundation Trust.

*** Donated inventories of DHSC centrally procured consumables: personal protective equipment in support of Covid-19 pandemic.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	**2,608**	1,712

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2021	31 March 2020
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	**£000**	£000
within one year	**0**	0
after one year, not later than five years	**0**	0
after five years	**0**	0
Total revenue allocated to remaining performance obligations	**0**	0

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2020/21	2019/20
	£000	£000
Income	**3,154**	5,958
Full cost	**(3,858)**	(3,068)
Surplus / (deficit)	**(704)**	2,890

The fees and charges income generated by the Trust include income from non-patient care income generation activities such as car parking, staff residences and catering. The objective is to ensure all costs associated with the operation of such activities are covered and that any surplus generated for the Trust is used to re-invest in the operation of its core services.

Note 6.1 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	**3,909**	3,694
Purchase of healthcare from non-NHS and non-DHSC bodies	**3,940**	1,391
Staff and executive directors costs**	**450,083**	406,288
Remuneration of non-executive directors	**142**	102
Supplies and services - clinical (excluding drugs costs)*	**82,763**	70,502
Supplies and services - general	**10,247**	10,877
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	**56,546**	56,932
Inventories written down	**347**	0
Consultancy costs	**1,568**	1,389
Establishment	**8,218**	5,894
Premises	**27,820**	23,084
Transport (including patient travel)	**2,074**	2,455
Depreciation on property, plant and equipment	**20,466**	19,846
Amortisation on intangible assets	**764**	662
Net impairments	**5,658**	(1,327)
Movement in credit loss allowance: contract receivables / contract assets	**519**	(651)
Audit fees payable to the external auditor		
audit services- statutory audit	**66**	63
other auditor remuneration (external auditor only)	**10**	6
Internal audit costs	**30**	170
Clinical negligence	**15,267**	12,718
Legal fees	**1,353**	557
Insurance	**163**	177
Research and development	**25,634**	25,740
Education and training	**8,581**	7,219
Rentals under operating leases	**2,855**	2,407
Redundancy	**104**	993
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	**3,025**	2,403
Car parking & security	**1,507**	1,290
Losses, ex gratia & special payments	**90**	0
Other services, e.g. external payroll	**151**	0
Other	**230**	1,851
Total	**734,130**	656,732
Of which:		
Related to continuing operations	**734,130**	656,732

* Includes £11.3m of donated inventories of DHSC centrally procured consumables: personal protective equipment in support of Covid-19 pandemic which have been consumed.

** Includes £5.0m annual leave accrual due to excess annual leave carried forward (above normal level) as a result of Covid-19 pandemic. This has been fully funded and is included within Other clinical income.

Note 6.2 Other auditor remuneration

	2020/21	2019/20
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the Trust	**0**	0
2. Audit-related assurance services	**10**	6
3. Taxation compliance services	**0**	0
4. All taxation advisory services not falling within item 3 above	**0**	0
5. Internal audit services	**0**	0
6. All assurance services not falling within items 1 to 5	**0**	0
7. Corporate finance transaction services not falling within items 1 to 6 above	**0**	0
8. Other non-audit services not falling within items 2 to 7 above	**0**	0
Total	**10**	6

Note 6.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2020/21 or 2019/20.

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	**0**	81
Changes in market price	**5,658**	(1,408)
Total net impairments charged to operating surplus / deficit	**5,658**	(1,327)
Total net impairments	**5,658**	(1,327)

The impairments relate to the impact of the full valuation of the Trusts land and buildings as at 31 March 2021, carried out by a Professional Valuer GVA Grimley Limited trading as Avison Young. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and Social Care and HM Treasury. Impairments are due to a reduction in the value of a number of the Trusts' building assets where no revaluation reserve balance exists.

Note 8 Employee benefits

	2020/21	2019/20
	Total	Total
	£000	£000
Salaries and wages	**363,648**	323,477
Social security costs	**34,165**	31,042
Apprenticeship levy	**1,630**	1,605
Employer's contributions to NHS pensions	**58,975**	54,543
Termination benefits	**182**	1,074
Temporary staff (including agency)	**5,282**	7,358
Total gross staff costs	**463,882**	419,099
Recoveries in respect of seconded staff	**(832)**	0
Total staff costs	**463,050**	419,099
Of which		
Costs capitalised as part of assets	**641**	600

Note 8.1 Retirements due to ill-health

During 2020/21 there were 3 early retirements from the Trust agreed on the grounds of ill-health (2 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £103k (£65k in 2019/20).

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

Note 9 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 for Health and Social Care 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 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 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

Note 10 Operating leases

Note 10.1 The Royal Wolverhampton NHS Trust as a lessor

This note discloses income generated in operating lease agreements where The Royal Wolverhampton NHS Trust is the lessor.

Included within this note are a number of third party services and retail outlets on site with whom the Trust have a leasing arrangement.

	2020/21	2019/20
	£000	£000
Operating lease revenue		
Minimum lease receipts	**745**	922
Total	**745**	922

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	**442**	579
- later than one year and not later than five years;	**253**	703
Total	**695**	1,282

Note 10.2 The Royal Wolverhampton NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where The Royal Wolverhampton NHS Trust is the lessee.

Included in this note is the arrangement for the lease of buildings from NHS Property Services which were previously owned by Wolverhampton City PCT. The value of this arrangement is £2.5m per annum, some of the leased properties transferring to the Trust and others being transferred to NHS Property Services. There are no other individually significant operating leases included in the figures below:

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	**2,855**	2,407
Total	**2,855**	2,407

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
- not later than one year;	**1,981**	2,030
- later than one year and not later than five years;	**4,395**	6,392
Total	**6,376**	8,422

Note 11 Finance income

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

	2020/21	2019/20
	£000	£000
Interest on bank accounts	**26**	186
Total finance income	**26**	186

Note 12.1 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:		
Finance leases	**16**	13
Main finance costs on PFI and LIFT schemes obligations	**467**	547
Contingent finance costs on PFI and LIFT scheme obligations	**1,627**	1,569
Total interest expense	**2,110**	2,129
Unwinding of discount on provisions	**(6)**	(3)
Other finance costs	**1**	0
Total finance costs	**2,105**	2,126

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2020/21	2019/20
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	**10**	4

Note 13 Other gains / (losses)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	**34**	53
Total gains / (losses) on disposal of assets	**34**	53
Total other gains / (losses)	**34**	53

Note 14.1 Intangible assets - 2020/21

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2020 - brought forward	**5,600**	**824**	**6,424**
Additions	**620**	**3,061**	**3,681**
Reclassifications	**1,106**	**(1,106)**	**0**
Valuation / gross cost at 31 March 2021	**7,326**	**2,779**	**10,105**
Amortisation at 1 April 2020 - brought forward	**3,815**	**0**	**3,815**
Provided during the year	**764**	**0**	**764**
Amortisation at 31 March 2021	**4,579**	**0**	**4,579**
Net book value at 31 March 2021	**2,747**	**2,779**	**5,526**
Net book value at 1 April 2020	1,785	824	2,609

Note 14.2 Intangible assets - 2019/20

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	4,022	1,756	5,778
Valuation / gross cost at 1 April 2019 - restated	4,022	1,756	5,778
Additions	218	428	646
Reclassifications	1,360	(1,360)	0
Valuation / gross cost at 31 March 2020	5,600	824	6,424
Amortisation at 1 April 2019 - as previously stated	3,153	0	3,153
Amortisation at 1 April 2019 - restated	3,153	0	3,153
Provided during the year	662	0	662
Amortisation at 31 March 2020	3,815	0	3,815
Net book value at 31 March 2020	1,785	824	2,609
Net book value at 1 April 2019	869	1,756	2,625

Note 14.3 Intangible non-current assets

Intangible assets are not revalued. They are valued at fair value using historic cost as an approximation.

Intangible assets are capitalised when they are capable of being used in a Trust's activities for more than one year, they can be valued and they have cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis, except capitalised Research and Development which is revalued using an appropriate index figure. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred. They are amortised over the shorter of the term of the licence and their useful economic lives, which is usually estimated at being 5 years.

Note 15.1 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**9,599**	**276,943**	**1,497**	**24,964**	**92,380**	**828**	**25,401**	**6,865**	**438,477**
Additions	**0**	**2,727**	**0**	**34,672**	**8,402**	**0**	**2,036**	**331**	**48,168**
Impairments	**0**	**(10,136)**	**0**	**0**	**0**	**0**	**0**	**0**	**(10,136)**
Reversals of impairments	**0**	**4,478**	**0**	**0**	**0**	**0**	**0**	**0**	**4,478**
Revaluations	**4,413**	**(3,159)**	**37**	**0**	**0**	**0**	**0**	**0**	**1,291**
Reclassifications	**0**	**40,948**	**0**	**(48,600)**	**4,381**	**51**	**2,743**	**477**	**0**
Disposals / derecognition	**0**	**0**	**0**	**0**	**(510)**	**0**	**0**	**0**	**(510)**
Valuation/gross cost at 31 March 2021	**14,012**	**311,801**	**1,534**	**11,036**	**104,653**	**879**	**30,180**	**7,673**	**481,768**
Accumulated depreciation at 1 April 2020 - brought forward	**0**	**0**	**0**	**0**	**63,670**	**600**	**19,905**	**5,918**	**90,093**
Provided during the year	**0**	**11,131**	**66**	**0**	**6,751**	**57**	**2,272**	**189**	**20,466**
Revaluations	**0**	**(11,131)**	**(66)**	**0**	**0**	**0**	**0**	**0**	**(11,197)**
Disposals / derecognition	**0**	**0**	**0**	**0**	**(510)**	**0**	**0**	**0**	**(510)**
Accumulated depreciation at 31 March 2021	**0**	**0**	**0**	**0**	**69,911**	**657**	**22,177**	**6,107**	**98,852**
Net book value at 31 March 2021	**14,012**	**311,801**	**1,534**	**11,036**	**34,742**	**222**	**8,003**	**1,566**	**382,916**
Net book value at 1 April 2020	9,599	276,943	1,497	24,964	28,710	228	5,496	947	348,384

Note 15.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	9,236	269,953	1,502	19,911	88,256	836	21,848	6,783	418,325
Valuation / gross cost at 1 April 2019 - restated	9,236	269,953	1,502	19,911	88,256	836	21,848	6,783	418,325
Additions	0	990	0	24,409	2,267	51	1,121	49	28,887
Impairments	0	(187)	0	(81)	0	0	0	0	(268)
Reversals of impairments	336	1,259	0	0	0	0	0	0	1,595
Revaluations	27	(6,988)	(8)	0	0	0	0	0	(6,969)
Reclassifications	0	11,916	3	(19,275)	4,887	4	2,432	33	0
Disposals / derecognition	0	0	0	0	(3,030)	(63)	0	0	(3,093)
Valuation/gross cost at 31 March 2020	9,599	276,943	1,497	24,964	92,380	828	25,401	6,865	438,477
Accumulated depreciation at 1 April 2019 - as previously stated	0	0	0	0	59,931	616	17,638	5,685	83,870
Accumulated depreciation at 1 April 2019 - restated	0	0	0	0	59,931	616	17,638	5,685	83,870
Provided during the year	0	10,466	64	0	6,769	47	2,267	233	19,846
Revaluations	0	(10,466)	(64)	0	0	0	0	0	(10,530)
Disposals / derecognition	0	0	0	0	(3,030)	(63)	0	0	(3,093)
Accumulated depreciation at 31 March 2020	0	0	0	0	63,670	600	19,905	5,918	90,093
Net book value at 31 March 2020	9,599	276,943	1,497	24,964	28,710	228	5,496	947	348,384
Net book value at 1 April 2019	9,236	269,953	1,502	19,911	28,325	220	4,210	1,098	334,455

Note 15.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021									
Owned - purchased	**14,012**	**302,362**	**1,534**	**11,036**	**28,995**	**222**	**8,003**	**1,551**	**367,715**
Finance leased	**0**	**0**	**0**	**0**	**1,185**	**0**	**0**	**0**	**1,185**
On-SoFP PFI contracts and other service concession arrangements	**0**	**8,620**	**0**	**0**	**2,230**	**0**	**0**	**0**	**10,850**
Owned - donated/granted	**0**	**819**	**0**	**0**	**2,332**	**0**	**0**	**15**	**3,166**
NBV total at 31 March 2021	**14,012**	**311,801**	**1,534**	**11,036**	**34,742**	**222**	**8,003**	**1,566**	**382,916**

Note 15.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned - purchased	9,599	268,281	1,497	24,964	23,799	228	5,496	930	334,794
Finance leased	0	0	0	0	1,381	0	0	0	1,381
On-SoFP PFI contracts and other service concession arrangements	0	7,878	0	0	2,937	0	0	0	10,815
Owned - donated/granted	0	784	0	0	593	0	0	17	1,394
NBV total at 31 March 2020	9,599	276,943	1,497	24,964	28,710	228	5,496	947	348,384

Note 16 Donations of property, plant and equipment

For the year ended 31 March 2021, The Department of Health and Social Care donated £1,770,000 of assets to the Trust in response to the Covid-19 pandemic and The Royal Wolverhampton NHS Trust Charity donated £179,000 of assets to the Trust.

The Royal Wolverhampton NHS Trust Charity was the donor of all assets donated to the Trust in the year ended 31 March 2020.

Note 17 Revaluations of property, plant and equipment

All property, plant and equipment are measured initially at cost, representing the cost 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 that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value under IFRS 13 where there are no restrictions preventing access to the market at the reporting date and if it does not meet the requirement of IAS 40 or IFRS 5.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts 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, modern equivalent asset basis.

The fair value of land and buildings is determined by valuations carried out by a Professional Valuer GVA Grimley Limited trading as Avison Young. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and Social Care and HM Treasury. A full valuation (excluding assets under construction/work in progress) was carried out as at 31 March 2021 and assets lives were also reviewed by GVA Grimley Limited trading as Avison Young as at this date. This valuation was based on published data from the Building Cost Information Service (BCIS) which provides a level of consistency in reporting and forecasting future trends. The valuation and the associated data was based on all in forecast Tender Price Index (TPI) as at 31 March 2021.

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, Borrowing Costs. Assets are revalued and depreciation commences when they are brought into use.

Note 18 Inventories

	31 March 2021	31 March 2020
	£000	£000
Drugs	**2,151**	2,244
Consumables	**6,344**	4,277
Energy	**132**	197
Other	**175**	183
Total inventories	**8,802**	6,901
of which:		
Held at fair value less costs to sell	**0**	0

Inventories recognised in expenses for the year were £65,712k (2019/20: £71,967k). Write-down of inventories recognised as expenses for the year were £347k (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 £12,457k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

These inventories at the year end have been measured at market prices, to reflect the net realisable value of the inventory. Where market prices are lower than the cost prices incurred by DHSC on Trusts' behalf, the difference has been recorded as a write-down of the inventory value.

Note 19.1 Receivables

	31 March 2021	31 March 2020
	£000	£000
Current		
Contract receivables	**21,851**	55,677
Allowance for impaired contract receivables / assets	**(1,838)**	(1,336)
Prepayments (non-PFI)	**4,379**	3,820
PDC dividend receivable	**436**	209
VAT receivable	**3,287**	1,707
Other receivables	**1,021**	743
Total current receivables	**29,136**	60,820
Non-current		
Prepayments (non-PFI)	**18**	18
PFI lifecycle prepayments	**5,451**	5,213
Other receivables	**1,857**	1,301
Total non-current receivables	**7,326**	6,532
Of which receivable from NHS and DHSC group bodies:		
Current	**15,417**	46,147
Non-current	**1,857**	1,301

Contract receivables have decreased during 2020/21 financial year as a result of the financial regime started on 1 April 2020 due to the Covid-19 pandemic. This has resulted in prompt payment due to the large block contract

Note 19.2 Allowances for credit losses

	2020/21	2019/20
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**1,336**	2,003
Allowances as at 1 April - restated	**1,336**	2,003
New allowances arising	**612**	434
Changes in existing allowances	**212**	(184)
Reversals of allowances	**(305)**	(901)
Utilisation of allowances (write offs)	**(17)**	(16)
Allowances as at 31 Mar 2021	**1,838**	1,336

Note 19.3 Exposure to credit risk

The Trust is recognising full lifetime credit losses on initial recognition. Balances with Department of Health and Social Care and associated agencies are assessed at zero credit risk, therefore are excluded from impairment calculation below.

	31 March 2021 other	31 March 2020 other
Ageing of impaired financial assets	£000	£000
0-30 days	**27**	66
31-60 days	**55**	38
61-90 days	**33**	82
91-180 days	**187**	108
Over 181 days	**1,536**	1,042
Total	**1,838**	1,336
Ageing of non-impaired financial assets past their due date		
0-30 days	**104**	1,428
31-60 days	**226**	427
61-90 days	**83**	164
91-180 days	**150**	596
Over 181 days	**2,239**	2,204
Total	**2,802**	4,819

Note 20.1 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	**12,045**	15,988
Net change in year	**42,306**	(3,943)
At 31 March	**54,351**	12,045
Broken down into:		
Cash at commercial banks and in hand	**21**	67
Cash with the Government Banking Service	**54,330**	11,978
Total cash and cash equivalents as in SoFP	**54,351**	12,045
Total cash and cash equivalents as in SoCF	**54,351**	12,045

Note 20.2 Third party assets held by the Trust

The Royal Wolverhampton 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
Monies on deposit	**1**	3
Total third party assets	**1**	3

Note 21.1 Trade and other payables

	31 March 2021	31 March 2020
	£000	£000
Current		
Trade payables	**6,630**	15,375
Capital payables	**10,780**	4,308
Accruals	**47,840**	35,047
Social security costs	**5,074**	4,669
VAT payables	**129**	141
Other taxes payable	**4,140**	3,629
Other payables	**6,286**	5,741
Total current trade and other payables	**80,879**	68,910
Non-current		
Other payables	**58**	68
Total non-current trade and other payables	**58**	68
Of which payables from NHS and DHSC group bodies:		
Current	**6,995**	8,359
Non-current	**42**	50

Note 22 Other liabilities

	31 March 2021	31 March 2020
	£000	£000
Current		
Deferred income: contract liabilities	**3,659**	3,300
Total other current liabilities	**3,659**	3,300
Non-current		
Total other non-current liabilities	**0**	0

Note 23.1 Borrowings

	31 March 2021	31 March 2020
	£000	£000
Current		
Obligations under finance leases	**196**	196
Obligations under PFI, LIFT or other service concession contracts	**1,816**	1,836
Total current borrowings	**2,012**	2,032
Non-current		
Obligations under finance leases	**893**	1,105
Obligations under PFI, LIFT or other service concession contracts	**4,683**	6,118
Total non-current borrowings	**5,576**	7,223

Note 23.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	**£000**	**£000**	**£000**	**£000**
Carrying value at 1 April 2020	**0**	**0**	**1,301**	**7,954**	**9,255**
Cash movements:					
Financing cash flows - payments and receipts of principal	**0**	**0**	**(211)**	**(1,836)**	**(2,047)**
Financing cash flows - payments of interest	**0**	**0**	**(16)**	**(467)**	**(483)**
Non-cash movements:					
Additions	**0**	**0**	**0**	**143**	**143**
Application of effective interest rate	**0**	**0**	**16**	**467**	**483**
Other changes	**0**	**0**	**(1)**	**238**	**237**
Carrying value at 31 March 2021	**0**	**0**	**1,089**	**6,499**	**7,588**

Note 23.3 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2019	0	0	1,466	8,529	9,995
Carrying value at 1 April 2018 - restated	0	0	1,466	8,529	9,995
Cash movements:					
Financing cash flows - payments and receipts of principal	0	0	(165)	(1,818)	(1,983)
Financing cash flows - payments of interest	0	0	(13)	(547)	(560)
Non-cash movements:					
Additions	0	0	0	32	32
Application of effective interest rate	0	0	13	547	560
Other changes	0	0	0	1,211	1,211
Carrying value at 31 March 2020	0	0	1,301	7,954	9,255

Note 24 Finance leases

Note 24.1 The Royal Wolverhampton NHS Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	31 March 2021	31 March 2020
	£000	£000
Gross lease liabilities	**1,166**	1,396
of which liabilities are due:		
- not later than one year;	**211**	211
- later than one year and not later than five years;	**822**	833
- later than five years.	**133**	352
Finance charges allocated to future periods	**(77)**	(95)
Net lease liabilities	**1,089**	1,301
of which payable:		
- not later than one year;	**196**	196
- later than one year and not later than five years;	**768**	775
- later than five years.	**125**	330
Total of future minimum sublease payments to be received at the reporting date	**0**	0
Contingent rent recognised as expense in the period	**0**	0

Note 25.1 Provisions for liabilities and charges analysis

	Pensions: injury benefits	**Legal claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
At 1 April 2020	600	208	6,135	6,943
Arising during the year	22	211	3,448	**3,681**
Utilised during the year	(31)	(136)	(675)	**(842)**
Reversed unused	0	(52)	(2,733)	**(2,785)**
Unwinding of discount	(6)	0	0	**(6)**
At 31 March 2021	**585**	**231**	**6,175**	**6,991**
Expected timing of cash flows:				
- not later than one year;	43	231	4,318	**4,592**
- later than one year and not later than five years;	175	0	0	**175**
- later than five years.	367	0	1,857	**2,224**
Total	**585**	**231**	**6,175**	**6,991**

Other includes: provisions for the possible return of money received by the Trust for contractual income, provisions for payments to be made regarding HR issues and provisions for VAT payments to HMRC.

Note 25.2 Clinical negligence liabilities

At 31 March 2021, £228,529k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Royal Wolverhampton NHS Trust (31 March 2020: £194,222k).

Note 26 Contingent assets and liabilities

	31 March 2021	31 March 2020
	£000	£000
Value of contingent liabilities		
Net value of contingent liabilities	**0**	0
Net value of contingent assets	**876**	575

In 2020/21, The Trust has submitted a VAT claim totalling £301k to H.M. Revenue and Customs under s.41(3) of the VAT Act 1994 in relation to cars that it leased to employees under salary sacrifice arrangements. This was in addition to the Fleming VAT reclaims. These totalled approximately £700k (2013/14 £700k) to H.M. Revenue and Customs under s.121 of the Finance Act 2008. During the Financial Year 2018/19 £125k plus £275k interest was received in respect to one of the Fleming VAT reclaims. The outcome and timing of the remaining balance of £575k of these claims is uncertain at 31 March 2021.

Note 27 Contractual capital commitments

	31 March 2021	31 March 2020
	£000	£000
Property, plant and equipment	**5,087**	20,745
Total	**5,087**	20,745

Note 28 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has one PFI scheme and this relates to the provision of Radiology services.

The Trust and Wolverhampton Radiology Limited Company No: 4235982 (formally trading as Impregilo Wolverhampton Limited) entered into a contract dated 20 March 2002 for the design, construction, financing and equipping of, and provision of certain services in connection with the provision of a new serviced radiology facility.

The agreement allows for Variations to the project. For example there were contract variations in 2004 and again in 2010 in line with service requirement.

Operational period of contract years is 30 years. The SPV is now Wolverhampton Radiology Limited (Company No: 4235982) of Third Floor, Broad Quay House, Prince Street, Bristol, BS1 4DJ.

Service payments are made to the operator monthly following the submission to the Trust of an invoice accompanied by a Payment Report and a Performance Monitoring Report which list any payment adjustments.

Under IFRIC 12, the substance of the contract is that the Trust has a finance lease and payments comprising of two elements - imputed finance lease charges and service charges. Details of the imputed finance lease charges are provided in the following tables.

Note 28.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2021	31 March 2020
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**8,181**	10,081
Of which liabilities are due		
- not later than one year;	**1,816**	1,836
- later than one year and not later than five years;	**4,334**	4,907
- later than five years.	**2,031**	3,339
Finance charges allocated to future periods	**(1,682)**	(2,127)
Net PFI, LIFT or other service concession arrangement obligation	**6,499**	7,954
- not later than one year;	**1,816**	1,836
- later than one year and not later than five years;	**3,508**	3,902
- later than five years.	**1,175**	2,217

Note 28.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2021	31 March 2020
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**77,418**	83,785
Of which payments are due:		
- not later than one year;	**6,424**	6,325
- later than one year and not later than five years;	**26,314**	25,956
- later than five years.	**44,680**	51,504

Note 28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2020/21	2019/20
	£000	£000
Unitary payment payable to service concession operator	**6,321**	6,171
Consisting of:		
- Interest charge	**467**	547
- Repayment of balance sheet obligation	**1,836**	1,818
- Service element and other charges to operating expenditure	**2,391**	2,237
- Contingent rent	**1,627**	1,569
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	**634**	166
Total amount paid to service concession operator	**6,955**	6,337

Note 29 Financial instruments

Note 29.1 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 Royal Wolverhampton NHS 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 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.

Credit risk

Because the majority of the Trust's income arises from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2021 are in contract receivables, as disclosed in the Trade and Other Receivables note.

Liquidity risk

The Trust's operating costs are primarily incurred under contracts with NHS Commissioning Organisations, 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.

Currency risk

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

Interest rate risk

The Trust borrows from the government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1-25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Market risk

The Trust is part of the NHS which is supported by the government and unless there is a major overall of healthcare provision, most importantly a reduction to access to free healthcare, then the Trust has low market risk.

Note 29.2 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	**21,034**	**21,034**
Cash and cash equivalents	**54,351**	**54,351**
Total at 31 March 2021	**75,385**	**75,385**

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	56,385	56,385
Cash and cash equivalents	12,045	12,045
Total at 31 March 2020	68,430	68,430

Note 29.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	**Held at amortised cost**	**Total book value**
	£000	**£000**
Obligations under finance leases	**1,089**	**1,089**
Obligations under PFI, LIFT and other service concession contracts	**6,499**	**6,499**
Trade and other payables excluding non financial liabilities	**65,308**	**65,308**
Total at 31 March 2021	**72,896**	**72,896**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
Obligations under finance leases	1,301	1,301
Obligations under PFI, LIFT and other service concession contracts	7,954	7,954
Trade and other payables excluding non financial liabilities	54,671	54,671
Total at 31 March 2020	63,926	63,926

Note 29.4 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 restated*
	£000	£000
In one year or less	**67,277**	56,718
In more than one year but not more than five years	**5,214**	5,740
In more than five years	**2,164**	3,691
Total	**74,655**	66,148

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

Note 29.5 Fair values of financial assets and liabilities

Book value used as a reasonable approximation of fair value for financial assets and liabilities.

Note 30 Losses and special payments

	2020/21 Total number of cases	2020/21 Total value of cases	2019/20 Total number of cases	2019/20 Total value of cases
	Number	**£000**	Number	£000
Losses				
Cash losses	**12**	**6**	1	0
Fruitless payments and constructive losses	**2**	**71**	3	0
Bad debts and claims abandoned	**33**	**17**	21	17
Total losses	**47**	**94**	25	17
Special payments				
Ex-gratia payments	**42**	**142**	48	106
Total special payments	**42**	**142**	48	106
Total losses and special payments	**89**	**236**	73	123

Note 31 Related parties

During the year none of the Department of Health and Social Care Ministers, Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with The Royal Wolverhampton NHS Trust.

The Department of Health and Social Care is regarded as a related party. During the year 2020/21 the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below where income and/or expenditure has been in excess of £500,000.

Birmingham Community Healthcare NHS Foundation Trust
Birmingham Women's and Children's NHS Foundation Trust
Black Country Healthcare NHS Foundation Trust
Midlands Partnership NHS Foundation Trust
The Dudley Group NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
Sandwell And West Birmingham Hospitals NHS Trust
Shrewsbury and Telford Hospital NHS Trust
University Hospitals Coventry And Warwickshire NHS Trust
University Hospitals of North Midlands NHS Trust
Walsall Healthcare NHS Trust
Worcestershire Acute Hospitals NHS Trust
NHS Birmingham and Solihull CCG
NHS Cannock Chase CCG
NHS Dudley CCG
NHS Herefordshire and Worcestershire CCG
NHS Sandwell and West Birmingham CCG
NHS Shropshire CCG
NHS South East Staffs and Seisdon Peninsula CCG
NHS Stafford and Surrounds CCG
NHS Telford and Wrekin CCG
NHS Wolverhampton CCG
NHS Walsall CCG
NHS England (Core & Regional Offices)
Health Education England
NHS Resolution (formerly NHS Litigation Authority)
Community Health Partnerships
Department of Health and Social Care
HM Revenue & Customs - Other taxes and duties and NI contributions
HM Revenue & Customs - VAT
NHS Pension Scheme
NHS Blood and Transplant
Wolverhampton City Council

The Trust has also received revenue and capital payments from a number of charitable funds for which the Trust acts as the Corporate Trustee, under the umbrella of Royal Wolverhampton NHS Trust Charitable Funds. Charitable funds held by the Trust are a related party as the Trust is Corporate Trustee for the funds.

Note 32 Events after the reporting date

The Royal Wolverhampton NHS Trust signed a five-year non-exclusive Strategic Research Agreement (SRA) with Sensyne Health plc. The agreement will enable the ethical application of clinical AI research to improve patient care and accelerate research into new medicines. Research will be undertaken to the highest standards of information governance and data security in accordance with NHS principles, the UK Government Code of Practice and data protection legislation. All data supplied to Sensyne will be anonymised by the Trust beforehand and the provision of the data will operate under an agreed Data Processing Protocol ("DPP") under the Trust's ethical oversight.

The Trust received 1,428,571 ordinary shares in Sensyne Health plc representing 0.9% of the existing issued share capital of Sensyne on 4 May 2021. The Trust will also receive from Sensyne an investment of up to £250,000 per year over the 5-year term of the contract for specific investments in NHS information technology to enable the curation and analysis of data under the SRA. The Trust will receive a royalty on revenues that are generated by Sensyne from the research undertaken under the SRA. The financial return the Trust receives from Sensyne will be reinvested back into the NHS to fund patient care. The Trust has entered into a lock-up agreement whereby it has agreed not to dispose of any shares for a period of two years from the date the shares are issued.

The Trust joins the partnership with 9 other NHS Trusts where Sensyne Health has signed SRAs bringing the total share ownership held by NHS Trusts in Sensyne to 13.3%. Sensyne Health also has additional project specific Data Access Agreements with a further NHS Trust in the UK and a health organisation in Scotland.
The Trust received approval for this agreement from Department of Health and Social Care on 30 March 2021.

Note 33 Better Payment Practice code

	2020/21	2020/21	2019/20	2019/20
Non-NHS Payables	**Number**	**£000**	Number	£000
Total non-NHS trade invoices paid in the year	**112,679**	**350,828**	114,108	315,653
Total non-NHS trade invoices paid within target	**88,793**	**306,637**	45,464	193,308
Percentage of non-NHS trade invoices paid within target	**78.8%**	**87.4%**	39.8%	61.2%
NHS Payables				
Total NHS trade invoices paid in the year	**4,688**	**50,677**	3,221	45,722
Total NHS trade invoices paid within target	**2,152**	**31,311**	1,121	24,857
Percentage of NHS trade invoices paid within target	**45.9%**	**61.8%**	34.8%	54.4%

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 34 External financing limit

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

	2020/21	2019/20
	£000	£000
Cash flow financing	**(12,982)**	15,420
External financing requirement	**(12,982)**	15,420
External financing limit (EFL)	**(7,370)**	18,046
Under / (over) spend against EFL	**5,612**	2,626

Note 35 Capital Resource Limit

	2020/21	2019/20
	£000	£000
Gross capital expenditure	**51,849**	29,533
Less: Donated and granted capital additions	**(1,949)**	(102)
Charge against Capital Resource Limit	**49,900**	29,431
Capital Resource Limit	**50,701**	29,431
Under / (over) spend against CRL*	**801**	0

* For 2020/21 there is an underspend against CRL of £801k which was expected from NHSI/E. This underspend is PDC paid to the Trust (in June 20) in respect of costs the Trust incurred in 2019/20 and self-funded. The PDC paid over in 2020/21 was a 'cash top-up' and the Trust has prudently used the PDC to reimburse its cash balances.

Note 36 Breakeven duty financial performance

	2020/21
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	**243**
Breakeven duty financial performance surplus / (deficit)	**243**

Note 37 Breakeven duty rolling assessment

	1997/98 to 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		8,035	7,964	9,297	8,688	7,891	3,663
Breakeven duty cumulative position	(7,438)	597	8,561	17,858	26,546	34,437	38,100
Operating income		289,830	306,023	374,417	384,917	394,045	461,810
Cumulative breakeven position as a percentage of operating income		0.2%	2.8%	4.8%	6.9%	8.7%	**8.3%**

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	153	8,542	4,327	3,021	5,735	**243**
Breakeven duty cumulative position	38,253	46,795	51,122	54,143	59,877	**60,121**
Operating income	509,405	536,028	548,538	592,975	676,114	**743,285**
Cumulative breakeven position as a percentage of operating income	7.5%	8.7%	9.3%	9.1%	8.9%	**8.1%**

NHS Improvement has provided guidance that the first year for consideration for the breakeven duty should be 2009/10. The Royal Wolverhampton NHS Trust is subject to a three year period for recovery of any deficit incurred.

Breakeven duty financial performance is determined as guided by NHS Improvement, in a manner consistent with previous years in this note.