NHS
Dudley Integrated Health and Care
NHS Trust

Annual Report and Accounts

2021-22

Chair and Chief Executive's Foreward

Penny Harris - Chief Executive Officer

Harry Turner - Chair

Welcome to our annual report for 2021/22. We began the financial year after responding to the first two waves of the Covid pandemic, moving into a more hopeful, but still difficult, few months with continued uncertainty as to what the future held globally, nationally and, within that, the role the NHS would play.

We want to start by thanking everyone for playing their part and making a difference. We have worked with you, and for you, as we have all adapted to new ways of working and living.

Against the Covid pandemic backdrop and a culture of 'virtual' practice and working, we have continued to establish and embed sound foundations and practices, develop, and expand our workforce and create an experienced and diverse Board and senior leadership team.

Sadly, we said goodbye to Paul Assinder who acted as Chief Executive from inception of the Trust in 2020. Paul, an exceptional and inspiring leader, retired at the end of 2021 with over 38 years of service in the NHS and will be sorely missed. We welcomed an Interim Chief Executive Penny Harris into the role from January 2022. Penny has considerable experience across acute and community landscape and is playing a pivotal role in the development of the integrated system model across the Black Country.

We are and continue to be enormously impressed by the 'can-do' attitude of our staff and the care and consideration they have shown for each other.

To support our staff, we have developed our staff health and wellbeing offer - to provide wide ranging support accessible to all staff in the organisation. We also saw a Covid vaccination uptake of 93% (first dose) and 91% (second dose) amongst our staff, which gives us confidence in the commitment of our workforce to protect themselves and the communities we serve.

Our staff have also let us know that they are happy and settled through local and national NHS staff surveys. These show that staff engagement has remained a high priority, despite the pandemic. Overall, we are proud of the results as they are an indicator of an engaged workforce and positive culture. This work will continue as we develop our staff engagement and organisational development programme throughout the Trust.

During another intense and difficult winter, we mobilised our staff quickly to support winter activity across the system. Our operational teams (supported heavily by corporate functions) have played an integral role in keeping the pace of this activity moving. We have helped to extend access to GP appointments and primary care-based services for children and young-people with respiratory syncytial virus by providing a Winter Access Hub at High Oak surgery.

This service was exceptionally well received by both patients and other NHS organisations across the patch (with a 98% attendance rate) and so successful that the service has been recommissioned to continue to help patients and GPs.

This has all been set against a backdrop of firsts for our organisation, namely we have; -

- Held our first (face-to- face) Annual General Meeting in September 2021 with over 100 guests including partners, patients, voluntary sector, and staff.
- Held our inaugural staff Away Day event in October 2021 – over 80% of staff attended the two sessions listening to colleagues and sharing best practice.
- Led the first Staff Awards and Staff Long Service event in early April 2022 recognising the contribution colleagues have made individually and as teams to the Trust and within the NHS.
- Been an integral part of the biggest vaccination programme in the world - Dudley's vaccination response earnt special mention in a Department for Health & Social Care paper, "Protecting the Adult Social Care sector: Good Practice for Local Booster Vaccination, Published 3 February 2022.

The Government 'Integration White Paper (IWP) – Joining Up Care for people, Places and Populations published in February 2022 provides a clear direction of travel for integration in the system and provides a framework for how that may be implemented at a local level through the Dudley Partnership Board. We have also been working with system partners in Dudley on the integrated care model which can be delivered to our local population, and this will be integral in how we grow and establish services over the coming months.

As we look ahead to 2022/23 those partnerships — will continue to be vital in delivering a post-COVID-19 recovery, and importantly in making in-roads into some of those long-term challenges we face before the pandemic hit. We look forward to the future with excitement and confidence.

The Board would like to thank all staff and partners who have worked with the Trust over the past year and their commitment to providing high quality care and services for the people of the Dudley Borough.

Contents

Performance Report

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

Performance Overview

The purpose of the Performance Overview is to provide key information about the Trust, our main objectives and strategies, and the principal risks that we face.

We have set this overview information out under the following headings:

- Our Trust and What We Do
  - Our Trust
  - Our local population
  - Our staff
  - Our services
  - Our system partners
- Activity Overview
- Our Aim, Purpose, and Commitments
- Our Key Achievements in 2021/22
- Our Key Risks and Issues
- Impact of Covid
  - On our services
  - On our staff

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

Our Trust and What We Do

Dudley Integrated Health and Care NHS Trust (DIHC) is a statutory body under the NHS Trust Establishment Order 2020 (No 078) created to provide integrated, community-based healthcare services to the people of Dudley. We serve a population of just over 331,000 people, with the aim of supporting "Community where possible, hospital when necessary".

The Trust is part of by the local system partnership in Dudley who are implementing a model of care that integrates primary care with community-based services to provide the optimum opportunity for caring for as many people as possible in their home. At the heart of what we do is putting patients first with care and wellbeing services and support wrapped around them. Our communities are diverse with a rich culture and heritage and DIHC are proud to be rooted in these communities and committed to improving healthy life expectancy and reducing health inequalities. Our focus is improving the health of our local population.

We employ some 354 staff who provide a range of services across our six Primary Care Network geographical localities, many provided from one of the 43 GP practices in the Dudley borough. We are a new type of NHS organisation and are focussed on supporting the development and sustainability of primary care. We work very closely with our Primary Care Networks (PCNs) and all of our practices to support them to deliver their services and develop out of hospital care. This support includes employing a number of PCN Additional Roles Reimbursement Scheme (ARRS) staff.

High Oak Surgery is now directly provided by DIHC. We have taken the opportunity to expand the offer of health services from the surgery, including co-locating an extended access GP hub with High Oak Surgery at Brierley Hill Health and Social Care Centre.

This project has enabled greater and speedier access for out of hours GP and primary care appointments for the people of Dudley. This was initially commissioned as a time limited service to assist over the winter period, but it has now been extended due to the success of the service.

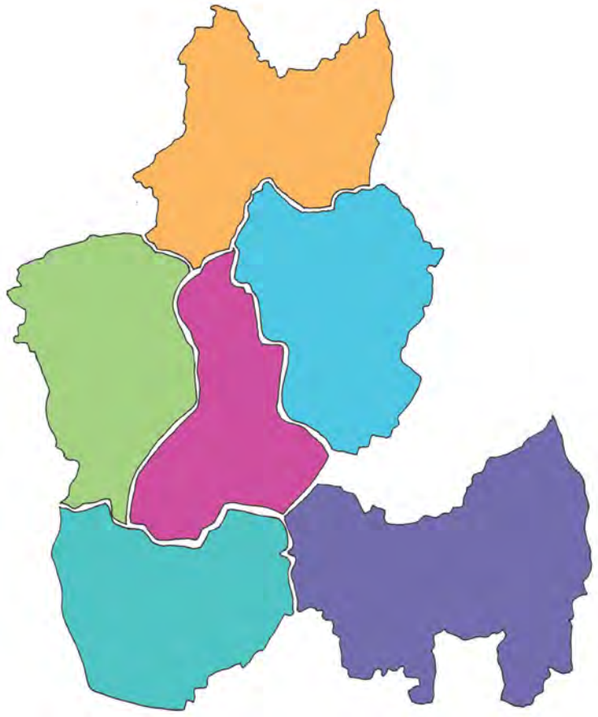
Patients are seen quickly and report a high degree of satisfaction with the service. We are now in the process of taking on the Chapel Street GP practice directly. These actions continue to support the Primary Care System in Dudley.

In addition, we are also contracted by the local Clinical Commissioning Group (CCG) to support the commissioning of community-based services.

Our Local Population

The Office of National Statistics records show the Dudley total population standing at just over 331,000, of which 59.1% are aged 18 to 64 and 20.3% are 65 and above. Around 14% of the population are from BAME backgrounds.

The vision for the Dudley system is **"Community where possible; hospital when necessary…."** Our aims, purpose and commitments describe the essence of our organisation and what we are here to achieve.



Dudley Borough

Our Staff

As of 31st March 2022, we employed 354 staff from across a broad spectrum of specialisms and backgrounds. On 1st April 2021, the Dudley School Nursing team transferred into DIHC along with a further cohort of PCN Additional Roles Reimbursement Scheme (ARRS) staff, meaning our staff numbers have continued to grow.

In addition, practice-based pharmacists were integrated into DIHC on 1st July 2021. We made every effort to welcome and support every member of transferring staff through a programme of cultural integration, which covered pre, during and post transfer, and the People Team continue to support new and existing staff with the growth and development of the organisation.

During 2021/22, we saw an addition of 63 Primary Care based staff recruited to provide services to the six Dudley Primary Care Networks (PCNs). These staff are employed by the Trust and provide clinical services to PCNs in a number of specialities under the PCN Additional Roles Reimbursement Scheme (ARRS).

Over the year we have also appointed to key roles in our corporate teams to support the safe delivery of our services and continue planning for our future growth.

A snapshot of our staff on 31st March 2022 is below.

Supported by the Board

Our workforce is supported by our very experienced, passionate, and committed Board. As well as being responsible for the day-to-day running of the organisation and its performance, the Board also provides compassionate leadership and sets the organisation's strategic aims, which have a strong emphasis on creating a great place to work, a restorative and just learning culture, and a culture of inclusivity. These ambitions align to the NHS People Plan, the link to which is NHS England » NHS People Plan

A Snapshot of our Staff on 31st March	Headcount
Corporate	33
Commissioning Support Services	18
Continuing Care including CYP and Intermediate Care	26
Medical Directorate	12
High Oak	10
IAPT	52
Primary Care Mental Health	14
Pharmacy	57
Primary Care Network	96
School Nursing	36
TOTAL	**354**

Our Services

Supporting Primary Care

Our relationship with primary care in Dudley is unique and is at the heart of our organisation and our purpose. We have continued to make significant progress in supporting General Practice, and Primary Care Networks (PCNs) in the services that they deliver to patients.

Throughout the Covid pandemic;

- Our pharmacy team has been integral and made a substantial contribution to the successful delivery of the vaccination programme.
- We provided a Covid assessment Centre for our practices to refer their patients in order to keep routine General Practice appointments operating throughout the pandemic – this was utilised by nearly 500 patients during the first quarter of the year.

Pharmaceutical Services

Our Pharmacy Team has worked tirelessly with system colleagues to implement and deliver the COVID-19 vaccination programme to the Dudley population. Of note has been the Team's success in implementing the vaccination programme across six primary care sites, at the Black Country Living Museum major vaccination hub, and in all of the Dudley Care Homes (over 100). We also provided vaccinations in all of Black Country Health Care NHS Tryst ('BCH') Mental Health Inpatient Units.

Collectively these services have vaccinated around 180,000 people, with the pharmacy team playing a key role in safe vaccine handling and governance within the sites. As a result, Dudley has consistently had very high vaccination rates.

Despite the focus on pharmaceutical support to the vaccination programme the pharmacy team has also been able to also progress work in the following areas:

- The Medicines Optimisation Quality Incentive Scheme.
- Audit work in practices on bisphosphonate drugs used to treat osteoporosis.
- Audit work on anticoagulant drugs to prevent strokes in patients with atrial fibrillation (a type of irregular heartbeat).

Priorities for 2022-23 include:

- Prescription Ordering Direct service (POD) to migrate to Medicines Optimization Support Hub (MOSH).
- Inclisiran – Implementation of the national clinical pathway for managing high cholesterol, including the provision of the new, NICE approved medicine Inclisiran.
- Heart failure and Entresto – Working with local cardiologists and their teams to improve the management of heart failure with medicines, including Dapagliflozin and Sacubitril / Valsartan.
- Repeat prescribing for patients taking high risk medicines – Development and implementation of systems to manage higher risk medicines which require regular blood tests.
- Non-medical prescribing (NMP) plans and support for ARRS roles - Implementation of a NMP policy which will support the safe expansion of prescribing roles for pharmacists, nurses and allied health professionals.

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

In terms of workforce development, during 2021/22 a significant exercise was undertaken to transfer around 40 pharmacists from CCG contracts to employed status with DIHC. Furthermore, new technician posts were developed and recruited to. At the end of the year the team was expanded with the recruitment of pharmacy technicians to complement the team capacity and expertise.

2022/23 will be a year of development for the team with the newly appointed Pharmacy Professional Development and Governance Lead undertaking a training needs assessment and developing the governance frameworks which aligns competency with the clinical role.

Case Study – DIHC Integrated Clinical Pharmacy Team supporting Primary Care Networks

During 2021/22 the pharmacy team embarked on an ambitious programme of change to move to an integrated employed workforce within DIHC supporting the delivery of medicines optimisation services in our primary care networks. The program for change has delivered a workforce combining the existing CCG pharmacists, the Prescription Ordering Direct service and the older persons pharmacy team alongside Primary Care Network pharmacists – a truly integrated clinical pharmacy team for primary care in Dudley.

The emergence of primary care networks responsible for the delivery of coordinated health and care services through multi-professional teams and Dudley Integrated Health and Care NHS Trust have provided the ideal platform needed to develop an integrated pharmacy service for the local population.

Over the past twelve months the team's structure has become further established aligning individuals within six distinct PCN teams.

As an integrated clinical pharmacy team, they have been able to provide a coordinated service in primary care key advantages have been:

- *Development of resilient teams at network level supporting every GP site in Dudley*
- *A focus on the development of all members of the team to maximise their potential*
- *Establishing a natural culture of mentorship, supervision and support within the team*
- *Developing a single integrated workplan aligned to the objectives of the CCG and DIHC*
- *Building a committed clinical pharmacy work force within DIHC who feel valued both personally and professionally*

There has been further expansion with the recruitment of pharmacy technicians and intern pharmacists to provide a comprehensive medicines optimisation service for Dudley. The team are now building on their established links with higher education institutions to support the development of their future workforce.

The team continues to work closely with strategic partners within Dudley as well as the wider integrated care system developing and delivering a wide-ranging work plan. At a practice level the team are embedded within the multidisciplinary team supporting colleagues and patients on all aspects of medicines optimisation.

There remains a strong emphasis within the team to underpin clinical delivery with a robust governance structure that will promote safe practice but also allow the team to continue its ambitious development within DIHC. A governance and development pharmacist has been appointed to lead on these areas for the team. As a priority in 2022/23 a comprehensive training needs assessment is being completed to ensure the team has the requisite competencies to deliver on its key objectives.

The teams' objectives remain focused on improving the safety and cost effectivity of prescribing, innovating with pioneering programmes clinical work and research, and most importantly improving the long-term health and wellbeing outcomes of the local population.

2022/23 will see the team further establish its integrated approach to clinical pharmacy services in primary care building on its core values and continuing to deliver as one coordinated team.

Clinical Professionals to Support in General Practice

The needs of our communities, particularly in areas where there are health inequalities, are greater than ever before. Our population is being impacted more and more by complex, long-term conditions. There is a growing concern about areas of longstanding health needs and the social determinants of health are a bigger focus than ever before.

These new challenges are increasing the pressure on the system to deliver for those in our communities and there is more that we can do to shift our focus from treating those who are unwell to preventing ill health and tackling health inequalities.

The creation of Primary Care Networks (PCNs) builds on the core of current primary care services and enables a greater provision of proactive, personalised and more integrated health and social care. Additional Roles Reimbursement Scheme (ARSS) professionals provide support to PCNs and GPs making support available to people where it is most needed.

The aim of the scheme is to build and utilise the additional roles to solve the workforce shortage in general practice. Whereas the funding will be for new roles being introduced within PCNs, each network will have the flexibility to determine which roles from a core list they require based on their patient population requirements. In consultation with PCN Clinical Directors, we assess the needs of the patient population to tailor recruitments based on population needs.

We entered into agreements with each of our PCNs to recruit, employ, train and operationally manage a range of healthcare professionals. This resulted in additional staff being employed on behalf of our PCNs and general practice in the following roles.

- Care Coordinators
- Dieticians
- First Contact Practitioner Physiotherapist
- Health and Wellbeing Coaches
- Primary Care First Contact Mental Health Practitioners
- Nursing Associates
- Occupational Therapists
- Paramedics
- Physician Associates
- First Contract Practitioner Podiatrists
- Social Prescribing Link Workers
- Listening and Guidance Social Prescribing Link Workers
- Practice-Based Pharmacists

At the request of Brierley Hill and Amblecote PCN, we have employed a PCN Clinical Director who is providing management support to that PCN to help deliver the PCN contract.

Supporting General Practice

The Pensnett Respiratory Assessment Centre (RAC)

In response to the Covid pandemic, most health economies established in primary care a ‘Red Centre’ to diagnose, and treat, those suspected of being infected with the virus.

The CCG commissioned DIHC to run the Pensnett Respiratory Assessment Centre , the work of whom has been highly commended. It has allowed GP practices to function well during the pandemic and reduced the pressure across other parts of the health care system. Patients who used the centre were very satisfied with the experience.

The Red Centre continued to operate until 30th June 2021. During the 15 months the Centre was open it saw 6,667 patients face to face who were either suspected or confirmed Covid positive. We worked with the West Midlands Academic Science Network and Dignio (a health informatics provider from Norway) to create a phone app to monitor “Oximetry @ Home”.

Patients were given Bluetooth-enabled oximeters and thermometers and entered data twice daily, which was monitored by the team. Patients came through the Red Centre directly and there were referrals from secondary care and the Urgent Treatment Centre. This enabled many patients to avoid hospital admission in the safe knowledge that any deterioration would be acted upon quickly.

We were delighted that the team at the Respiratory Assessment were awarded the Freedom of the Borough Award in May 2022 by Dudley Council.

Case Study – Walk and Draw

In Dudley and Netherton Primary Care Network (PCN) we have a shining star who is passionate about making a difference with the communities she works with.

Meet Grace. Grace is the Social Prescribing Link worker for migrants, asylum seekers, refugees and for people who do not speak English. Her job involves client contact and building relationships of trust with patients to enable them to access health and social care as well as community services which they would have otherwise not accessed because of language barriers, lack of self-confidence, poor digital skills and lack of knowledge about available services, entitlements and rights they have. Grace speaks from the heart, and has gone through the same experience our patients are going through which strengthens that trusted relationship.

Since starting her role, she has hit the floor running. Her relaxed and practical approach has seen her working collaboratively with the voluntary sector and colleagues in Integrated Plus to develop a Walk and Draw Group. Centred around the St James ward of Dudley, she has connected patients into gentle activity through art and greenspace; walking, drawing and taking note of nature and surroundings. Gentle conversations have blossomed into friendships and a sense of solidarity. Despite the language barriers, patients have shared the horrors of escaping conflict and turmoil in their own countries, the frustration of not being able to communicate effectively as non-English speakers and the hardship of finding suitable housing and employment. Many of the patients have complex political, economic and social barriers as well as mental health problems, most commonly post-traumatic stress disorder, so it is important they are supported with integrating into Dudley.

Grace said, "I find satisfaction knowing clients who have undergone unimaginable circumstances have finally found meaning to life".

"It's amazing to discover people's strength using a personalised and solution focused approach. This promotes confidence and independence hence helping them to manage their mental and physical health; finding solutions to their day-to-day problems and to heal from their trauma. It's also fantastic to get to use my interpersonal skills; compassion, the ability to listen, flexibility, intuition and sensitivity and how when applied effectively can make a difference in people's lives".

Alireza has been attending the walk and draw sessions and said, "Sometimes I feel so bad that I can't talk to anyone, but in the group I can talk to all of the members. They make me feel relaxed and I love being part of this".

This positive approach has given GPs in central Dudley and Netherton an option to provide a non-medical referral that can operate along side existing treatments to improve health and wellbeing of migrants. Patients have reported improved mental health and improved language skills through access to schools and colleges. Some have found work, found adequate housing thus preventing homelessness. They have received access to information and rights and been able to navigate the healthcare system that is rather unfamiliar and complex for people who can't speak English.

Case Study – Advanced Clinical Specialist Practitioner in ME/CFS & chronic pain

Ange is in her late 50s and has spent almost a lifetime dedicated to working in the NHS. She suffers with fibromyalgia and has vision difficulties in the dark and went to see her GP with pain and fatigue. The GP referred Ange to Debbie who is an Advanced Clinical Specialist Practitioner in ME/CFS & chronic pain and works in Netherton and Dudley Primary Care Network (PCN).

Debbie and Ange spent an hour talking through issues and solutions and Debbie wrote letters to Ange's employer about making reasonable adjustments to support her better in work. Ange's workplace made the changes, and the effect was fabulous. Debbie said the next time she saw Ange, she was 'looking up and was more confident'. Ange said to Debbie that 'I am more than just work!'.

With Ange's confidence blossoming she decided she wanted to join a gym and follow a healthier diet. Debbie supported Ange with an eating plan and Ange

realised that she could do this by herself and agreed to see Debbie in 4 weeks' time.

Debbie said that she feels very privileged to meet so many inspiring patients. She said that being able to spend time to really understand them and help them explore who they are and what they are capable of really let's them tackle their issues. She is there to build confidence and reassure and said that patients are really grateful to have that one-to-one support.

Ange said she felt really honoured to have met Debbie and turn her life around and to be featured in an annual report.

"DIHC is an exciting place to be," said Debbie. "I have the freedom and flexibility to work with patients on their level and to make a really positive difference to their health and wellbeing. That's why I love my job here at DIHC."

Winter Access Hub

In Autumn 2021 Primary Care was asked to increase their Extended Access appointments to add capacity to a pressurised system.

At the request of our CCG and PCNs, in just in just two and a half the Trust was able to stand up a team of people who put together Dudley's "Winter Access Hub".

The service operated between 1pm and 10pm Monday to Friday and between 9am and 7pm on a Saturday and gave primary care an additional 326 face-to-face appointments each week. It was located in DIHC's own GP Practice, High Oak Surgery at the Brierley Hill Health and Social Care Centre.

In addition to the overflow from GP surgeries, the service also takes significant volumes from 111 and Dudley's Urgent Treatment Centre.

The capacity has increased steadily and now offers 402 face-to-face GP appointments per week plus 44 smear appointments, 75 phlebotomy appointments and a home visiting service for vulnerable patients with learning disabilities or mental health problems to complete their annual health checks.

During the period January – March 2022, the centre treated 3,311 people face to face, with 82% being seen within 15 minutes of arriving at the centre.

Due to the success of this programme, the GP side of the hub has been commissioned by the CCG for a further three months until the end of June 2022. The Commissioners of this service and our PCN Clinical Directors wish to further support this service beyond June and the model is being considered by other parts of the Black Country following its success.

General Practice - High Oak Surgery

In October 2020, Dudley CCG awarded DIHC an Alternative Provider Medical Services (APMS) contract for a GP Surgery based in High Oak, Pensnett.

There is an ongoing conversation, led by the CCG, around the future of the Pensnett premises. During 2021-22 DIHC commissioned the Transformation Unit to conduct a listening exercise so to hear the views of High Oak Surgery patients and the wider public. We remain engaged with local councillors and others as we seek the optimal solution for our patients.

Working closely with GP colleagues, we have worked to transform the service offering at High Oak.

The practice had relied heavily on locums for many years. We have moved non-medical staff onto Agenda for Change contracts and have engaged the services of a salaried Clinical Lead GP and a salaried ACP Pharmacist, thus moving away from full reliance on temporary/agency staff. As a result of this:

- our GP-Patient survey results are excellent.
- our quality scores (Dudley Quality Outcomes for Health) are improving.
- flu and other vaccination rates are better than ever.

We anticipate High Oak becoming a teaching practice for GPs in the next year and will explore the possibilities of training other staff groups, especially Nursing Assistants and Physicians Associates within our PCN. Our list size as of 26th April 2022 was 3,969.

During this financial year High Oak continues to operate from the Brierley Hill Health and Social Care Centre and has undergone a number of changes. The clinical model is being delivered by a team of regular locums. A team of DIHC senior staff have become more involved in the operating and systems of High Oak Surgery and one of the administration team is being trained as office manager.

The team has been able to start creating the framework that DIHC will use for all its joining GP practices going forward.

Looking to the future we have a Practice Nurse retiring and further PCN staff joining us to compliment the Physiotherapist, Physicians Associate, and Pharmacist that have joined the team. This change is giving us chance to look at the current skills mix to determine what staff would benefit the population most going forward. The CCG has also granted funding to convert two non-clinical rooms to clinical use allowing us to expand the services we offer.

General Practice - Chapel Street Medical Practice

On 1st December 2021 a management arrangement was entered into with Chapel Street Medical Practice to provide clinical and business management support, with a view to ensuring that the patients can have access to high quality General Medical Services.

The practice has a registered list size of 2,650 patients residing in and around Lye and Stourbridge. There is a team of non-clinical staff working at the surgery, many of whom are multi-lingual and able to support patients' needs in other languages.

Chapel Street has had some intensive input from the Trust under the management arrangement in 2021-22 with particular focus on supporting the practice to address concerns raised on a recent Care Quality Commission inspection.

Attention was given to providing clinical staff to the practice during contracted hours, including improving the variety of clinicians available to patients by adding appointments from a practice-based pharmacist and a paramedic to the nurse and doctor team. Processes around safe prescribing of medicines and care of patients with long term conditions have been the focus over the last few months.

As the arrangements continue into 2022-23, the Trust aims to further improve services for this registered population.

Provider Services

Primary Care Mental Health Services and Dudley Talking Therapies (Nationally known as Increasing Access to Psychological therapies – (IAPT))

Within the Trust there are two Mental Health Teams – Dudley Talking Therapies (IAPT) and Primary Care based Mental Health Teams. During the Covid pandemic, these teams have enthusiastically adopted new ways of remote working. Simultaneously, they have embraced a full development programme across mental health teams.

The Primary Care Mental Health Teams and Talking Therapies teams have undertaken three proof of concept models and have redesigned their referral triage processes as a result. In performance terms, these services have exceeded historical KPIs and benchmark amongst the best performers in the ICS.

In addition DIHC has supported Primary Care Networks ("PCNs") in Dudley to extend the existing pilots of First Contact Practitioner Mental Health Nurses across all six PCNs.

The Improving Access to Psychological Therapies (IAPT) programme began in 2008 and has transformed the treatment of adult anxiety disorders and depression in England. Dudley was one of the first teams to be trained. IAPT is widely recognised as the most ambitious programme of talking therapies in the world and in the past year alone more than one million people accessed IAPT services for help to overcome their depression and anxiety, and better manage their mental health.

The priorities for service development are:

- Work-force development - A system wide approach across the Black Country to look at the necessary investment for IAPT to be sustainable. Additional funding has been made available and the process to recruit additional trainees is planned.
- Focusing on people with long-term conditions. Two thirds of people with a common mental health problem also have a long-term physical health problem, greatly increasing the cost of their care by an average of 45% more than those without a mental health problem. By integrating IAPT services with physical health services the NHS can provide better support to this group of people and achieve better outcomes.
- We have made good progress in this over the last year working closely with colleagues to develop the holistic Long-Covid pathway to ensure all individuals who present wit Long Covid are given quick access to psychological support. We are also developing a bespoke diabetes digital pathway with other IAPT sites across the Black Country.
- Supporting people to find or stay in work. Good work contributes to good mental health, and IAPT services can better contribute to improved employment outcomes. The team has close working relationships with 'Thrive into Work' and has attended events with the local job centre to support people with mental health needs back into work.
- Improving quality and people's experience of services. Improving the numbers of people who recover,

reducing geographic variation between services, and reducing inequalities in access and outcomes for some population groups are all important aspects of the development of IAPT services. This is an area we hope to focus on more in the coming years as the workforce grows so we can adequately address and respond to demand.

- IAPT has also been involved with promotional events across the borough including Tough enough to care promoting men's mental health and the involvement of the promotion of staff wellbeing and a Trust wide mindfulness group which is facilitated by our experienced clinicians.
- One of the biggest achievements over the last year was the successful retention of our qualifying trainees, continuing to offer a wide range of therapeutic interventions in a number of formats and being able to restore to a blended way of working to ensure those that need to be seen face to face are and that the staff remain so dedicated to delivering a high level of care.

School Nursing Service

The School Nursing Service joined DIHC in April 2021, following the successful transfer from Shropshire Community Health NHS Trust. The team comprises of 35 colleagues, which is a mix of:

- Registered nurses
- Specialist school nurses
- School nurse support workers
- Administration staff

Case Study – School Nurses - Managing Children's Anxiety Together in a Group – Meet - Laura Bickley, Queen's Nurse, School Nurse, DIHC – published May 2021

School Nurses deliver work across health and education systems to help provide a link between school and home and their expertise allows us to protect and promote the physical, mental, and emotional health and wellbeing of children and young people.

Laura Bickley is one of our fabulous School Nurses and the Team Lead and has also been awarded the prestigious Queens Nurse Award. Laura has been a Paediatric Nurse for nineteen years and a Specialist Community Public Health Practitioner (School Nurse) for eleven years.

Laura has done a considerable amount of work with primary age children (8-11y) supporting their anxiety and emotions. As there were 5 children who needed support Laura felt that meeting with the children as a group on a regular, consistent basis would be the fastest and most appropriate way of treatment. Before group sessions commenced each child was met with individually to explain the programme of support and if they were happy to meet with their peers in a group session. All the children were happy to meet to see if they were comfortable talking in a group. As it was a small primary school, all the children knew of each other, which was a positive start.

During the first session the children themselves established some ground rules. Laura also gave each child the opportunity to say how they felt, what they thought their issues were and if they had previously tried any strategies to help cope with them, I have a stress ball that I squeeze,' one child announced. Another child said he would be taken for a 'drive in the car'.

As each week went by, each child would become more chatty and happier to share any worries they had, strategies they have tried, and generally how they have felt over the week. Some of the coping strategies (their tool kit) included breathing exercises and a worry jar to help them deal with anxiety either at school or at home and encourage resilience.

Following each session each child added to their emotional health first aid kit motivation box. They identified some of their own strategies for coping when they felt worried or anxious and placed the 'tools' in their kit. This made it easier for young children to feel confident that they could reach into their toolkit and pull out a strategy they could use when needed.

Other sessions looked at overall health and wellbeing of children and young people which included healthy eating, the importance of enough sleep and the benefits of exercise

To help other children in the school, the group also created some posters to display in the school about what they

had learnt about coping with anxiety and managing their emotions. At the end of the sessions the children fed back that they were useful and fun and had learnt 'how to cope with things.' One even said that he would like to 'help other children.' Their class teachers also thanked me for running the group and told me that the children had become more positive, empowered and less anxious over the following weeks. This kind of work not only helped these children be more confident and successful in school but has also taught them techniques they can rely on throughout their lives.

The School Nursing Team helps deliver the Healthy Child Programme to promote improved outcomes of children and young people to help them reach their full potential, not inhibited by poor health within the local health economy and gives advice on high impact areas within school nurse model e.g. immunisation, nutrition, life style issues, emotional and behavioural issues.

Our team of school nurses also provide a public health service for families identified in Healthy Child Programme in accordance with the agreed standards/ policies which promote equalities within the CQC standards of care expected. We have successfully contributed to the community development work of Dudley working in partnership and close co-operation with relevant agencies and colleagues.

Over the past year our team have successfully delivered the following:-

- *Hit targets for national child measurement programme*
- *Supported with the 12 -15 years vaccination programme for Covid*
- *Transfer from RiO Electronic Patient Records system to EMIS. This is aligned to other key DIHC services and has significantly improved collaborative cross-service working*
- *Successfully undertaken health and safety risk assessments in the schools we currently work within which has enabled important conversations regarding Health and Safety. This has resulted in several key actions and issues to progress the resolution of throughout 21/22. Particularly, the resolution of all H&S issues specific to Progress Point has been a significant milestone for the team*
- *Increased referrals especially around emotional health and wellbeing*
- *Successful recruitment to our Team Leader post as a permanent full-time role. Appointing to this key role has improved team stability and provided continuity of leadership.*
- *Establishment of a EMIS handbook, created in-house and regularly updated in line with new functions and applications.*
- *Achieved Significant Assurance status from Internal Auditors*

Continuing and Intermediate Healthcare

The team have been responding to a variety of system pressures over the last 12 months.

They actively contribute to the discharge meeting (for complex discharges/patient referrals) on a daily basis and are a key member of the bed bureau meetings which happen twice a day. Both are seven days a week.

716 patients have been assessed and discharged into intermediate care units (pathway 2) and 1,214 pathway 3 patients have been discussed and agreed through bed bureau. The team complete clinical calls to all patients in pathway 3/spot purchase beds to ensure they are safe and well and discharge plans are progressing. For intermediate care units, the team also lead weekly multi-disciplinary teams where patient rehabilitation goals and discharge plans are discussed.

307 patients had full Continuing Healthcare assessments for long term care needs and 647 were assessed and supported with fast track end of life care.

An operational manager for the team is also on call to respond to any discharge issues/funding requests from the acute trust 7 days a week.

Additional actions taken by the team over the past 12 months to support system pressures include:

- Nurse support to the Covid vaccination programme both to the public and care home residents
- Supporting the trusted assessor role within the acute trust as and when needed
- Clinical support to Intermediate Care units as and when required including manager support
- Social care assistant support to sourcing domiciliary care packages for access by the whole system to maximise the number of individuals being supported in their own home. A total of 76 additional packages were commissioned over the peak winter months at a time when care capacity was extremely limited. The role was also used to source 31 complex care home placements for continuing care and end of life patients during the same time period. This brokerage model has proved to be extremely beneficial and plans are being developed to continue this service longer term

Children and Young Peoples Continuing Care

The Children and Young Peoples Continuing Care Nurse Assessor transferred from the CCG into DIHC and has continued to promote the importance of inclusion and personalisation for the children and young people of Dudley.

Over the past year they have:

- Ensured all children and young people who are eligible for continuing care receive support that is personal and tailored to their needs via a Personal Health Budget (PHB)
- Improved governance and processes for Children and Young People PHB PA clinical training needs
- Supported the initiative to face fit test all personal assistants and parents of children receiving a direct payment PHB during the heights of covid to ensure continuation of care
- Successfully initiated a process to support the co-ordination of timely assessments for continuing care and Education, Health, and Care Plans.
- Transferred all patient records to the electronic patient record
- Supported the timely transition of children and young people from hospital to community-based care and from children and young people's services into adult services
- Continued to strengthen the relationships between health, education and social care
- Chaired and continues to host the Children and Young Peoples Continuing Care and PHB network for the West Midlands

Commissioning Support Services

Within DIHC we have a team of Strategic Commissioning and Transformation leads who are responsible for service development and the commissioning of some community-based services which is contracted for by the CCG. This includes mental health, physical health, older adults, long term conditions, end of life, primary care and children and young people's services. The team work closely with system partners to ensure that the services provided are meeting the needs of our local population. They also support operational teams with any service development support they require.

Our System Partners

Our Trust, like all others in England and Wales, now operates as part of an Integrated Care System (ICS). The ICS brings together organisations responsible for providing health and care across an area, so that they can work in collaboration for the benefit of the local population. Most ICSs were formed on the 1st of April 2021, and have shared plans, goals, and objectives.

We are part of the Black Country and West Birmingham ICS (BCWB ICS), which covers a population of 1.5 million people. As part of the ICS, we work closely alongside 14 other health and care organisations to shape the best health and care outcomes for our communities:

Working closely alongside 14 other healh and care organisations	
Black Country and West Birmingham Clinical Commissioning Group	Black Country Healthcare NHS Foundation Trust
Dudley Metropolitan Borough Council	Birmingham Community Healthcare NHS Trust
The Dudley Group NHS Foundation Trust	Birmingham City Council
City of Wolverhampton Council	Sandwell and West Birmingham Hospitals NHS Trust
The Royal Wolverhampton NHS Trust	Sandwell Metropolitan Borough Council
West Midlands Ambulance Service	Walsall Metropolitan Borough Council
NHS England & Improvement	Walsall Healthcare NHS Trust

There are five localities or 'places' within our ICS, and DIHC sits within Dudley 'place'. All the five 'places' that make our ICS's geography are shown below in figure 1:

Figure 1. Area of BCWB ICS

Activity Overview

To support reporting of our performance against the National Operational Standards, National and Local Quality Requirements and to support the delivery of the key performance indicators within the oversight framework we use an integrated performance dashboard to enable effective monitoring.

Dudley Integrated Health and Care Trust Scorecard							
Area	**Type**	**Metric Source**	**Metric**	**2021/22 Target**	**Outturn 2020/21**	**Outturn 2021/22**	**Comments**
Quality Care Outcomes	Safe	SOF	CQC Rating - Community MH Services		* Good	* Good	*see note 1
		SOF	CQC Rating - High Oak Surgery		* Good	* Good	
		SOF	CQC Rating – Community health services for children, young people, and families		* Good	* Good	
		NHS Standard Contract - NQR	Duty of Candour		1	1	
		SOF	Incidents		91	138	*see note 9
		NHS Standard Contract	Occurrence of any Never Event		0	0	
		SOF	Patient safety alerts completed by deadline		100.0%	100.0%	
		SOF	Serious Incidents		1	1	*see note 9
		SOF	Staff Flu Vaccination		67.1%	52.0%	
		Local	Staff Covid Vaccination - First dose		80.0%	93.0%	
		Local	Staff Covid Vaccination - Second dose		56.6%	91.0%	
		Local	Staff Covid Vaccination - Booster			75.0%	

Dudley Integrated Health and Care Trust Scorecard (Continued)							
Area	**Type**	**Metric Source**	**Metric**	**2021/22 Target**	**Outturn 2020/21**	**Outturn 2021/22**	**Comments**
Quality Care Outcomes	Caring	SOF 20/21	Written complaints – rate		1.3%	0.8%	
		NHS Standard Contract - Sch6	Complaints		19	31	
		NHS Standard Contract - Sch6	Informal Concerns		39	20	
		NHS Standard Contract - Sch6	Compliments		3	47	
		Friends and Family Test					
		SOF	Staff - % recommended – care		see note 2		
		SOF	High Oak Surgery - % Positive				
		SOF	Mental Health - % Positive		99.2%	99.6%	
		SOF	Proportions of patient activities with an ethnicity code			95.1%	*See note 3
		Improving Access to Psychological Therapies (IAPT)					
		NHS Standard Contract - LIR	Data Quality Maturity Index (DQMI) – IAPT dataset score		Avg. 97.5% per month	* Avg. 95% per month	* Refer to note 4
		SOF	IAPT Access rate as a rate of prevalence	24.7%	15.7%	18.7%	
		NHS Standard Contract - LQR	% Number of people entering treatment against target	100.0%	68.8%	75.6%	

Dudley Integrated Health and Care Trust Scorecard (Continued)							
Area	**Type**	**Metric Source**	**Metric**	**2021/22 Target**	**Outturn 2020/21**	**Outturn 2021/22**	**Comments**
Quality Care Outcomes	Effective	NHS Standard Contract - LQR	Number of people entering treatment - Trajectory		7,743	9,309	
		NHS Standard Contract - LQR	Number of people entering treatment - Actual		5,327	7,033	
		SOF	Percentage of people completing a course of IAPT treatment moving to recovery	50%	45.6%	42.7%	
		SOF	Percentage of people waiting i) 6 weeks or less from referral to entering a course of talking treatment under Improving	75.0%	97.2%	91.3%	
		SOF	Percentage of people waiting ii) 18 weeks or less from referral to entering a course of talking treatment under improving	95%	99.1%	98.2%	
		Primary Care - High Oak Surgery					
		SOF	Access to general practice – number of available appointments		38,420	42,183	
		Local	% Appointment Utilisation		55.1%	67.5%	
		SOF	Number of people receiving flu vaccination		46.9%	55.0%	see note 10
		SOF	% of adults vaccinated for Covid 19 - First dose		86.2%	69.1%	see note 6 & 7

Dudley Integrated Health and Care Trust Scorecard (Continued)

Area	Type	Metric Source	Metric	2021/22 Target	Outturn 2020/21	Outturn 2021/22	Comments
Quality Care Outcomes	Effective	SOF	% of adults vaccinated for Covid 19 - Second dose		16.8%	63.6%	see note 6 & 7
		SOF	% of adults vaccinated for Covid 19 – Booster			47.8%	
		SOF	Number of people with a learning disability on the GP register receiving an annual health check	75.0%	94.7%	88.9%	
		SOF	Population vaccination coverage – MMR for two doses (5 year olds) to reach the optimal standard nationally (95%)	95.0%	94.9%	90.3%	
		SOF	Cervical screening coverage, females aged 25-64, attending screening within target period	80.0%	68.3%	69.4%	
		SOF	Diabetes patients that have achieved all the NICE-recommended treatment targets (adults and children)		18.3%	19.4%	
		SOF	People with severe mental illness receiving a full annual physical health check and follow up interventions		29.0%	42.9%	
		SOF	Number of people with CVD treated for cardiac high risk conditions		27.6%	51.3%	

Dudley Integrated Health and Care Trust Scorecard (Continued)

Area	Type	Metric Source	Metric	2021/22 Target	Outturn 2020/21	Outturn 2021/22	Comments
Leadership and Workforce	Organisational Health	SOF	Staff Sickness	4.68%	2.04%	3.15%	
		SOF	Staff Turnover	10%	9.14%	21.75%	
		NHS Standard Contract - Sch6	Mandatory Training Compliance	90%	73.18%	91.22%	
		SOF	Number of registered nurses employed by the NHS (WTE)		32.1	54.9	
		SOF	Number of doctors working in general practice (WTE)		0.36	0.4	
		SOF	Additional primary care WTE through ARRS		56.4	75.5	
		SOF	Number of healthcare support workers employed by the NHS		1	2.7	
		SOF 20/21	Proportion of temporary staff		18.30%	14.50%	
		NHS Staff Survey					
		SOF	**People Promise and theme**				**Benchmark**
		SOF	We are compassionate and inclusive	10.0		7.60	**7.9**
		SOF	We are recognised and rewarded	10.0		6.70	**6.7**
		SOF	We each have a voice that counts	10.0		6.90	**7.3**
		SOF	We are safe and healthy	10.0		6.40	**6.4**

Dudley Integrated Health and Care Trust Scorecard (Continued)

Area	Type	Metric Source	Metric	2021/22 Target	Outturn 2020/21	Outturn 2021/22	Comments
Leadership and Workforce	Organisational Health	SOF	We are always learning	10.0		5.40	**6.2**
		SOF	We work flexibly	10.0		6.80	**7**
		SOF	We are a team	10.0		6.90	**7.3**
		SOF	Staff engagement	10.0		7.00	**7.4**
			Morale	10.0		6.20	**6.3**
		SOF 20/21	NHS Staff Survey - Staff recommendation of the organisation as a place to work or receive treatment		76.36%	69.97%	see note 11
		SOF	Proportion of people who report that in the last three months they have come to work despite not feeling well enough to perform their duties		37.0%	41.0%	
		SOF	Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns		74.0%	70.0%	
		SOF	Proportion of staff who agree that their organisation acts fairly with regard to career progression/ promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age		89.0%	66.0%	

Dudley Integrated Health and Care Trust Scorecard (Continued)

Area	Type	Metric Source	Metric	2021/22 Target	Outturn 2020/21	Outturn 2021/22	Comments
Leadership and Workforce	Organisational Health	SOF	Reducing/ eliminating bullying and harassment from managers and other staff Providers				
		SOF	% experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public			18.9%	
		SOF	% experienced harassment, bullying or abuse at work from managers			7.8%	
		SOF	% experienced harassment, bullying or abuse at work from other colleagues			9.4%	
		SOF 20/21	Effectiveness of shared objective-setting and teamworking Providers				
		SOF 20/21	% agreeing that their team has a set of shared objectives			74%	
		SOF 20/21	% agreeing that their team often meets to discuss the team's effectiveness			67%	
		SOF 20/21	Providing equal opportunities and eliminating discrimination Providers				

Dudley Integrated Health and Care Trust Scorecard (Continued)							
Area	**Type**	**Metric Source**	**Metric**	**2021/22 Target**	**Outturn 2020/21**	**Outturn 2021/22**	**Com-ments**
Leadership and Workforce	Organisational Health	SOF 20/21	% experiencing discrimination from their manager/team leader or other colleagues in the last 12 months			4%	
		SOF 20/21	The BME leadership ambition (WRES) re executive appointments.				see note 7
Finance	Financial Sustainability	SOF 20/21	Capital service capacity		0.2	0.5	
		SOF 20/21	Liquidity (days)		139	73	
		SOF 20/21	Income & Expenditure (I&E) margin		0.37%	2.56%	
	Financial Controls	SOF	Performance against financial plan		£38,000 favourable	£537,000 favourable	
		SOF 20/21	Agency spend		55.39% favourable	23.31% favourable	
		SOF 20/21	Overall Score		2	2	

Points to note:

1. Dudley Integrated Health and Care Trust is two years old and therefore we have reported the latest CQC scores for those services which have transferred into the organisation:

- The latest CQC score for IAPT, and Primary Care Mental Health service refers to the legacy organisation Dudley Walsall Mental Health Trust - Community based Mental Health services for Adults and Older Adults. This inspection took place in January 2020 and the report published in March 2020.
- The latest CQC Score for High Oak Surgery was inspected in September 2016 and the report was published in October 2016.
- The latest CQC score for Community Health Services for Children, Young People and Families service refers to the services legacy rating for Shropshire Community Health NHS Trust. The inspection took place in January 2019 – March 2019 and the report was published 1 August 2019.

2. Friends and Family Test (FFT) was postponed due to the coronavirus pandemic. We have continued to report mental health FFT data.

3. The proportion of records with an ethnicity code only relates to IAPT data.

4. Data Quality Maturity Index (DQMI) – IAPT dataset score was not available for March 2022 at the time of reporting.

5. The cohort for the 2020/21 Covid vaccination programme includes residential care homes patients, health & social care workers, patients aged 50+ with or without underlying health conditions, 16-64yrs with underlying health conditions.

6. The cohort for the 2021/22 Covid vaccinations programme; Residential care homes patients, health & social care workers, patients aged 5+ with or without underlying health conditions.

7. Our ambition is to grow diversity within the Executive Team and work towards at least 20% of the board being from a BAME background over the next 5 years.

8. An increase in reported incidents is expected due to our growth in provision. Additionally, there has been a focus on incident reporting, training, and awareness to support a culture of transparency, openness and learning.

9. Staff Covid Vaccinations commenced in the latter part of 2020/21.

10. The High Oak surgery flu vaccination % includes all at risk categories. It is not just limited to 65+ age range.

11. In 2020/21 there were only two service eligible to participate in the staff survey (IAPT & Primary Care Mental Health). The volume of services has increased since this point.

Managing Performance

Over the course of 2021/22, the Trust has continued to work with Midlands and Lancashire CSU (MLCSU) to enhance its Business Intelligence function.

The key achievements for Business Intelligence in 2021/22 include:-

- During Q2 and Q3, we have transferred the Business Intelligence function for School Nursing, and Primary Care Mental Health services which enabled us to enhance the breadth of reporting for these services and review data at a more granular level enabling the Trust to identify potential opportunities for service and data quality improvement.
- A successful roll-out of the EMIS clinical system to the School Nursing service with development of bespoke data input templates and user training.
- The creation of the data warehouse which is hosted by Midlands and Lancashire CSU and a successful migration of new and existing data flows to enable in-house reporting.
- We have strengthened our reporting this year across four domains by developing a scorecard which has a core set of indicators and is reviewed each month by the senior leadership team and the Board. The four domains are as follows:

    - Finance
    - Quality and Safety
    - Workforce
    - Operational performance

In addition, we are developing service level performance reports and have commenced the rollout of these during this financial year.

DIHC has developed a programme of Service Reviews across the four domains in order to effectively support continuous improvement. This then features as part of our Trust Management Board, and where necessary to the Trust's Executive Committee and to the Board Assurance Committees in relation to issues of assurance.

- Implemented the production of statutory returns for IAPT and Community datasets and established the process for improving data quality within these returns.

The key aims for Business Intelligence and Performance in 2022/23 will include:

- Continued development and implementation of performance and information reporting for the Trust.
- Review existing information systems to ensure that they are fit for purpose for an integrated provider Trust.
- Continue to maintain full compliance with the Data information Standards.
- Identify and develop data quality processes to ensure that data is accurate, timely and fit for purpose.

Our Aim, Purpose and Commitments

Aim

Dudley first: Community where possible, hospital when necessary.

We are truly different. We are a new type of NHS organisation created to serve the Dudley population in a genuinely integrated way.

Purpose

To connect with the people of Dudley, embrace our diversity and support them to live longer, healthier lives.

We will do this by ensuring everyone involved in the provision of care works together, keeping the person at the heart of everything they do.

Commitments

Put people first, we will:

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

Enable and support our staff, we will:

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

Simplify what can be complex, we will:

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

Be accountable for our actions.

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

Our Key Achievements in 2021/22

In 2021/22 the Covid-19 pandemic continued to change the way we live, including through UK social distancing regulations, national and local lockdown restrictions, and the prevalence of new Covid-19 variants.

Despite the challenges that 2021/22 presented to all the health and social care sector, DIHC has worked together with partners to deliver many great achievements over the past 12 months. This year we have once again made a real and positive impact to our Dudley community by providing safe, effective, and personalised services.

2021/22 highlights include:

We continued to mobilise teams to rapidly respond to the national Covid-19 vaccination roll out and subsequent booster roll outs. This ensured our communities had the opportunity to readily access a vaccination against Covid-19 and included a Care Home vaccination programme for which we received national recognition. We offered and provided vaccinations in all of BCH's Mental Health inpatient Units across the whole of the Black Country. We also continued to provide our Covid-19 Assessment Centre in the first quarter of 2021/22 to help practices remain operational and resilient by assessing and treating patients with suspected Covid-19 in a separate and specifically designed location.

We successfully delivered our first staff away day 'Moving Forwards Together' on the 20th of October 2021. This was a highly successful event that received lots of positive feedback. The day involved several engagements and listening session events and led to the generation of our Moving Forwards Together Action Plan with 17 key 'You Said, We Did' areas.

We continued to grow our substantive workforce with key appointments to our DIHC Board, and to our clinical, operational, and corporate teams.

We continued to grow our Additional Role Reimbursement Scheme (ARRS) workforce, covering 13 different and crucial roles in the community such as Physician Associates, Social Prescribing Link Workers, and Dieticians. In doing so we have successfully managed, planned for and monitored out spectrum of ARRS staff in alignment with the requirements set out in the Primary Care Network Directly Enhanced Services (DES) contract.

We worked to stand up a highly regarded and effective Winter Access hub between January – March 2022, enabling an increased numbers of face-to-face GP appointments. The model has been recognised regionally as an exemplar of best practice and included both same day primary care appointments and a children's and young peoples (CYP) clinical hub, providing an additional 400+ appointments per week Monday – Saturday. In addition, the Hub has seen further expansion to include weekend phlebotomy and smear clinics and a long-term condition (LTC) clinic/home visiting service.

We worked in lockstep with the people of Dudley this year, delivering several events and engagement sessions to the heart of our community. This included the Tough Enough to Care event promoting men's mental health, our Community Connect session promoting our services, Suicide prevention and awareness workshops, and other events enabled by our strong connections with our grassroots voluntary sector in Dudley.

Performance Against 2021-22 Objectives

Objective	1. Award of the ICP contract
Anticipated Outcome	Successful completion of transactions review and ISAP processes to provide high quality patient services to the Dudley population on 1st April 2022
Status	Paused
Progress	Work has paused on the procurement being led by the CCG whilst system partners work on developing an integrated care model for the Dudley population. In March 2022 system partners came together to design a new model of integration for Dudley. This work will continue into 2022/23.

Objective	2. Integrate and develop existing services
Anticipated Outcome	Provide and develop our patient services to a high standard, undertaking service transformation and development work where required.
Status	Achieved
Progress	The services within DIHC have been supported through a process of integration and development to focus on improving the quality of services and population health during the year 2021/22.

Objective	3. Safe transfer of services into DIHC
Anticipated Outcome	Plan and co-ordinate effectively the safe and smooth transfer of children's services and adult community services into DIHC by 1st April 2022.
Status	Paused
Progress	The proposed transfer of further services to DIHC has been paused whilst Dudley system partners work together to develop an integrated care model for the Dudley population. In March 2022 system partners came together to design a new model of integration for Dudley. This work will continue into 2022/23.

Objective	4. Develop and deliver the DIHC Organisational Development Strategy
Anticipated Outcome	Plan and develop the organisation to be an inclusive model employer that champions equality and diversity, engages and involves existing and future staff in the development of DIHC, its culture and services.
Status	In progress
Progress	An ongoing development programme of clinical and corporate governance arrangements alongside enhancements to strategic and operational effectiveness has been in place throughout 2021/22. Work has continued with our staff to develop the services and culture within DIHC. Work is underway on our Equality and Diversity Strategy which will be published in late spring of 2022, and we have developed our Inclusion Network and Staff Forum. We continue to work alongside our system partners to develop the model of integrated care for our population and undertake regular work with our public and patient groups to develop our services.

Objective	5. Be a learning organisation that is rooted in the heart of its local community
Anticipated Outcome	Ensure the voices of the community and staff are heard, taking account of voices that are quieter. Taking time to seek out opinions and experiences and listen actively to what people are telling us and shaping services to reflect the needs of our local population. Working with our staff to support them as ambassadors of DIHC.
Status	Achieved
Progress	Our relationship has continued to evolve with our patients, communities and wider population and stakeholders. We work closely with partners who already have a strong relationship as we recognise that trust is essential. Our Board hear a patient/service story at every meeting which brings to life our teams and communities and helps cement the learning from a grass roots level. We produce reports/infographics following specific workshops so that feedback can help shape services and patient journeys thus improving patient experience. We have a Staff Forum, an Allyship and Inclusion Network and Allied Health Professionals & Nursing Forum that meet regularly and raise any issues of concern or share good practice.

Objective	6. Development of the working partnership between DIHC and Primary Care
Anticipated Outcome	Continue to develop the relationship with primary care including developing the primary care support package, the agreement for provision of services to PCNs and implement the Population Health ICP model of care.
Status	Achieved
Progress	Our relationship with primary care has continued to grow and flourish throughout 2021/22. We have developed service level agreements with our PCNs to recruit and deliver primary workforce, developed workforce and estates plans for our PCNs and employed a Clinical Director and management support in one our PCNs. We have also developed our support offer to primary care by offering management and clinical support to run practice services and are in the process of development sub-contracting arrangements with one of practices. We have also provided extended access through the winter months and provided support through the vaccination programme with our pharmacy and co-ordination teams.

Objective	7. Work with system partners to restore services effectively
Anticipated Outcome	Participate and influence the ICS planning and restoration programme, including the ongoing support to primary care and the vaccination programme
Status	Achieved
Progress	Our teams have been supported to restore their services with increased levels of face-to-face provision whilst realising the benefits that virtual care can provide to some of our population. We have supported local provider colleagues with our teams supporting early discharge to enable services to be restored. We have continued to support primary care to deliver their services with enhanced workforce and support to the vaccination programme. We also support our Care Homes to enable them to operate to their maximum ability and have implemented one of the most successful Care Home vaccination programmes in the country.

Objective	8. Develop DIHC in the place-based partnership
Anticipated Outcome	Working with ICS and local system colleagues, and by being a community partner, lead the development of the place based integrated care partnership in Dudley whilst supporting the wider development of the ICS.
Status	In progress
Progress	DIHC has led the development of the place-based partnership in Dudley alongside colleagues from the CCG, the Council and the local Mental Health and Acute Trusts. This has included enabling the development programme for the Partnership Board that has taken place throughout 2021/22 and leading the process to undertake the national Place Based Development Programme which was launched in February 2022. Work will continue with system colleagues as the Dudley place develops its governance and operational arrangements in readiness for legislation changes planned for July 2022.

Objective	9. Demonstrate effective use of resources and be a sustainable organisation
Anticipated Outcome	Be a sustainable organisation from both an environment and economic sense. Continue to make efficient and effective use of financial, workforce and estate resources and plan accordingly for future demand.
Status	Achieved
Progress	DIHC has ended 2021/22 with a surplus balance and continues to demonstrate efficient and effective use of resources. The Green Plan for 2022 to 2025 has been approved and its principles is being integrated into key supporting strategies including car scheme and expenses as well as reducing travel miles for staff and service users.

Objective	10. Develop the Full Integration Strategy for Primary Care
Anticipated Outcome	Using national and international best practice and in consultation with primary care.
Status	In progress
Progress	DIHC has made significant progress in relation to the offers it is able to make to primary care to support sustainability. Full integration is a specific component of an award of an Integrated Care Provider (ICP) contract. Pursuing work on the award of this contract was paused in October 2021 whilst DIHC have worked with system partners to develop an integrated care model for the Dudley population. To enable the support to primary care to continue to develop, DIHC has developed alternative arrangements including a management arrangement with a practice to undertake management and clinical operational responsibilities for the practice on behalf of the partners, and the ability for DIHC to be sub-contracted to provide GMS services. The suite of offers to primary care will continue to be developed throughout 2022/23.

Our Key Risks and Issues

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

The eight key risks to our plans were identified as:

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

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

Impact of Covid

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

At DIHC this has been demonstrated by the extensive partnership with primary care, secondary care providers and acute partners across all levels, from front line service delivery to Board commitment and support and for the needs of the Black Country and West Birmingham STP and not just for our own service users across Dudley. One example has been the joint working across the system to support the mass vaccination programme.

Impact of COVID on our Other Services

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

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

Impact of COVID on our Staff

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

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

We also developed a digital staff wellbeing booklet with key information for staff to support them keep well and healthy, this included the Black Country Health and Wellbeing Hub which has been a pivotal mental health resource during the pandemic. As a Trust we also shared Mental Health& wellbeing online sessions for all staff to attend.

Performance Analysis

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

- A Performance Analysis
- Financial Performance Summary
- Greener NHS
- Quality Performance Report
- Engagement with the public, service users and stakeholders
- Engagement with staff
- Improving equality of service delivery to different groups
- Workforce Performance Summary including Equality, Diversity and Inclusion
- Health and Safety at Work
- Modern Day Slavery and Human Trafficking
- Counter fraud, Bribery and Corruption

A Performance Analysis

A summary of our performance against the key national standards is shown in the previous section restoration priorities determined by NHS England/ Improvement.

These priorities from a performance perspective, are focused on maximising activity undertaken in order of meet the recovery and restoration priorities as determined by NHSEI.

As a Trust we are committed to ensuring that we treat all our service users equally and are working with partners across the system to understand the complexities behind these health inequalities, why they exist and how they can be removed.

Financial Performance Summary

The Trust performed well financially during the year, in an environment challenged by several factors including the ongoing Covid-19 pandemic and uncertainty regarding the timing of service transfers.

The table summarises the Trust's performance against the key financial duties for the year ended 31 March 2022.

Requirement	Target 2021/22	Performance 2021/22	Outcome 2021/22
Expenditure does not exceed income	Breakeven	£537k surplus	Achieved
Remain within Capital Resource Limit (CRL)	488k	485k	Achieved
Achieve capital cost absorption rate of 3.5%	3.5%	3.5%	Achieved
External Financing Limit is not exceeded	£975k	£975k	Achieved

The Trust also maintained a strong balance sheet, with net current assets of £1.0m and total assets of £0.9m. Cash flow was positive, and the Trust closed the year with a cash balance of £4.2m.

The comparative information for the 2020/21 financial year is included within the table below.

Requirement	Target 2020/21	Performance 2020/21	Outcome 2020/21
Expenditure does not exceed income	Breakeven	£38k surplus	Achieved
Remain within Capital Resource Limit (CRL)	£0	£0	Achieved
Achieve capital cost absorption rate of 3.5%	3.5%	3.5%	Achieved
External Financing Limit is not exceeded	£178k	£178k	Achieved

Where does the Trust's income come from?

The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22, most of the Trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, with funding envelopes being set at an Integrated Care System (ICS) level.

How is the Trust's money spent?

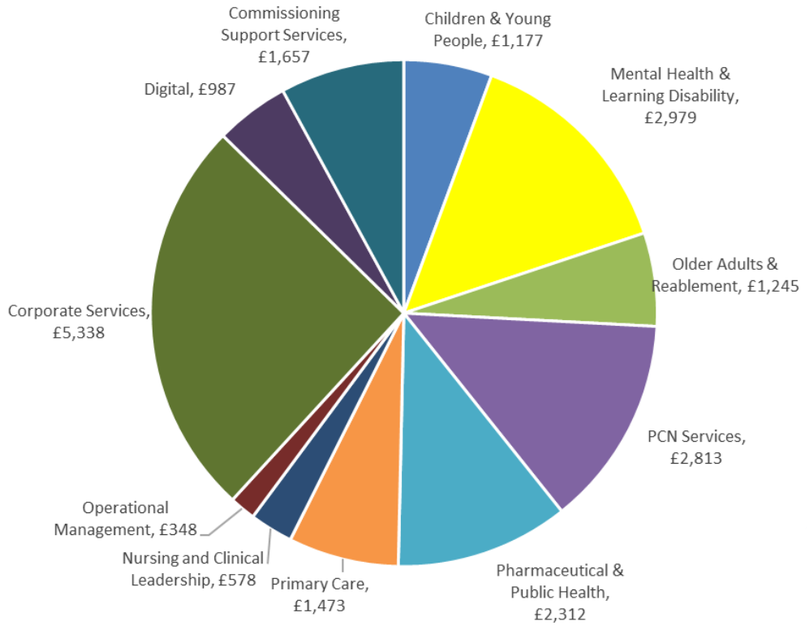
The Trust invested the £20,907k resources received in the delivery and management of the services transferred to date, which primarily comprised Primary Care Mental Health and Improving Access to Psychological Therapy services, the High Oak General Practice, Primary Care Network Staff through the Additional Roles Reimbursement Scheme and School Nursing Services.

The Trust has also developed its corporate functions over the last year to ensure that it has the necessary services in place to support the front-line services it delivers and to enable the organisation to continue to grow in safe and effective manner.

In addition to the directly provided services, the corporate services function also supports the delivery of a number of Dudley place based commissioning services to Black Country and West Birmingham CCG including the management of significant budgets held by the CCG in relation to NHS Continuing Healthcare (£25m)*, prescribing (£59m)* and support with the commissioning of a number of community based commissioning contracts.

*Source – BCWB CCG

The chart below summarises the areas of expenditure.



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

Capital Expenditure

The Trust incurred capital expenditure of £475k in the 2021/22 financial year, funded from its own internal resources and a grant of £247k received from the Department of Health and Social Care. Of this, £438k was spent on the purchase of IT assets as part of the ongoing digitisation of the Trust's services, with the remainder on reconfiguration of the Trust's office space.

There was no capital expenditure incurred in 2020/21.

Payment of Suppliers

Better Payment Practice Code

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

2021/22 Performance	Number	Value £'000
Non-NHS Payables		
Total Non-NHS trade invoices paid in the year	2,796	7,891
Total Non-NHS trade invoices paid within target	2,785	7,865
Percentage of Non-NHS trade invoices paid within target	99.6%	99.7%
NHS Payables		
Total NHS trade invoices paid in the year	189	4,453
Total NHS trade invoices paid within target	189	4,453
Percentage of NHS trade invoices paid within target	100%	100%

Going Concern

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

Whilst there is a presumption of going concern status for NHS Trusts that deliver services that will be provided by the public sector both now and in the future, our first accounts also reported a small operating surplus and we are, at the time of this report, planning a balanced budget for 2022/23. This is a major achievement within the current economic climate, with significant inflationary pressures affecting the NHS.

We are confident in our future growth as part of the Dudley Health and Care system, which will enable us to reach a more stable and sustainable size and income base. Dudley Integrated Health and Care NHS Trust, The Dudley Group NHS Foundation Trust and Black Country Healthcare NHS Foundation Trust have been working together in the local system to further integrate healthcare services for all in Dudley.

Greener NHS

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.

Climate change impacts represent one of the biggest health care challenges of this century, which surfaces itself in the form of extreme weather conditions, increased food and water insecurity and increase in infectious diseases.

In 2020, the NHS became the first national health system worldwide to commit to 'Carbon Net Zero'.

DIHC, recognising its responsibility of delivering high quality health care, which is also socially, economically, and financially sustainable, has formulated and adopted its Board approved three-year Green Plan for the year 2022-25.

Healthcare services have the potential to cause significant impact on the environment and being a sizeable consumer of natural resources, results in becoming a contributor of carbon emissions, and we realise there is a need to change the way we operate. Thus, we need to choose sustainable ways to travel, deliver our care and procure material, without significantly impacting the environment.

Covid-19 has resulted in swift progress in terms of sustainability, for example the roll out of remote working for office-based staff and the ability to hold virtual meetings has reduced staff travel and the associated vehicle miles and emissions. Better use of technology like telecare and telehealth, establishing virtual clinics for appointments has also eliminated significant patient travel and minimised care miles. Even with the Government's lifting of Covid restrictions we are in the process of planning for new ways of working with the Trust moving from an online to a hybrid mode of operation. The Trust will introduce monitoring systems which allow the calculation of avoided carbon resulting from these new ways of working.

DIHC also co-chairs the Black Country and West Birmingham (BCWB) Green Travel Working Group, which meets at least monthly, and has since early 2020 provided a platform to share best practice, as well as support and challenge each other.

Our Aim

We recognise that sustainable development is a critical factor in our organisation being able to deliver world class healthcare, both now and in the future. We desire to achieve more with less by better utilisation of resources.

We are therefore dedicated to enabling the creation and embedding of sustainable models of care throughout our operations and to making sure that our operations, and our estates, are as efficient, sustainable, and resilient as they possibly can be.

Key headlines for 2021-22

- Formulation and adoption of Green Plan 2022-25
- Developed Sustainability Impact Assessment which is used to review processes either. in development or review. We will be adopting the ICS SIA to support assessment for Business Development, Investment and Procurement Decisions.
- The Executive lead for Sustainability is the Chief Executive and the Non-Executive lead is the Chair of the Audit & Risk Committee.
- Quarterly reporting against the green agenda to the Trust Board and Finance, Performance and Digital Committee.
- Participating in the wider green agenda through membership of the ICS Sustainability Network and ICS Greener NHS Greener Travel workstream group.
- Actively encourage a culture of sustainability within our operating model and business as usual activities and with staff.
- Inclusion of sustainability in the Induction Pack for new staff and inviting all staff interested in promoting sustainability to join the 'Green Team' in order to emphasise that all staff has a role to play.
- Development of sustainable models of care by introducing initiatives to deliver care closer to home, preventing admission or attendance at hospital, maximising the use of health centres or similar facilities to reduce travel, and maximising the use of digital technologies.
- Committed to reduced paper use and deliver the NHS Plastic Reduction Pledge to no longer purchase single-use plastic straws and stirrers (April 2020), cutlery, plates, or single use cups (April 2021) and after April 2022 as part of the Green Plan for 2022 to 2025 reflect on wider single use plastic food, containers and plastic cups including covers and lids.
- The national guidance for Greener Campaigns Toolkit is being adapted to launch our own staff awareness initiatives including updating of our own intranet and website to raise awareness and signpost staff to guidance.
- In the process of developing a Green Travel Plan to promote reduced vehicle use and electric charge points at buildings supported by an installation programme.
- Move towards purchasing 100% renewable electricity from our energy suppliers during 2022/23.

Quality Performance Report

Dudley Integrated Health & Care NHS Trust are committed to continuously improving the quality and safety of the services that we provide.

We have established systems and processes to focus on encouraging and supporting clinical and operational staff to reflect on the service they provide to ensure we learn individual, service level and organisational lessons. We seek to learn from what goes well and what needs to improve. Wherever possible, we share lessons learnt to prevent harm alongside acknowledging, promoting and celebrating good practice. DIHC will continue to do everything we can to support staff to be reflective and responsive to learning opportunities by developing their knowledge, skills and confidence in managing risk informed learning. In addition, the organisation is committed to ensuring teams are supported in extracting relevant data and undertaking thematic reviews by our business intelligence function.

For 21/22, we identified a broad range of Quality Priorities that reflected the developmental phase of the Trust in its first year of being in existence.

Building on this, the priorities identified for 22/23 represent a much more focussed approach around the three core elements of quality and safety – safe, effective and experience.

How we identified our Quality Priorities for 2022/23

Initial thinking centred on further strengthening the Trust's approach to continuous quality improvement to include patient safety, clinical audit, and engagement. These initial ideas were then developed further through discussion and engagement with our staff and with patient representative groups; these conversations included a discussion with 'Dudley Voices for Choices' to help shape how we engage with people with Learning Disabilities. The engagement sessions confirmed that we are focussing on priorities that are important to our patients and provided a wealth of feedback that has subsequently been incorporated into the quality priorities we are taking forward during the coming year.

These quality priorities are described on the next page.

Safe	
What are we going to do?	
• Implementation of the Patient Safety Incident Response Framework (PSIRF) • Strengthening of the patient safety specialist role • Roll-out of the patient safety syllabus for staff including mandatory compliance and recording	
Why we chose this	**How will we measure (our) success?**
We are an organisation that wants to ensure continuous learning and improvement in our services. We want to ensure that patients are protected from avoidable harms and that we are supportive of our teams to be open about mistakes and concerns.	• Compliance with the Trusts agreed KPI for mandatory training (KPI to be agreed) – e-learning for health patient safety syllabus • An agreed Trust framework for involving patients in patient safety and evidence of this in action • Providing additional training for staff in review of patient safety incidents • Improvements in relevant staff survey responses

Effective	
What are we going to do?	
To develop a robust clinical audit programme (at organisational and service level) including associated training	
Why we chose this	**How will we measure (our) success?**
Implementing robust clinical audit and learning from the outcomes can significantly improve patient care It can make more effective use of clinical time and helps to advance practice. Clinical audit is a core component of the Trusts clinical governance framework, and we want to focus on developing our teams to be able to undertake good, quality and meaningful clinical audit.	• Develop a clinical audit programme for 22/23 which is developed through engagement with our services and patients • Demonstrating that we are undertaking all relevant national clinical audits • Providing training to teams (KPIs to be determined) • Demonstrate that we are widely learning and sharing audit findings across the Trust and the system as appropriate • Implement a clinical audit end of year showcase for teams

Experience	
What are we going to do?	
• Equality Inclusion and Diversity, improving access to services for people with a learning disability or autism • Increase the rate of annual health checks for people over 14 years and on a GP learning disability register (national target 75%) and improve the accuracy of GP Learning disability registers within our primary care services • Bereavement EOL work for individuals with LD • Implement the Oliver McGowan Mandatory training in Learning Disability and Autism	
Why we chose this	**How will we measure (our) success?**
Evidence suggests that people with learning disabilities have greater healthcare needs that the general population and that these needs are often unmet. As an organisation with a clear focus on population health and health inequalities we want to ensure that we are accessible to individuals with learning disability making any reasonable adjustments required.	• Exceeding the national target for rate of annual health checks for people over 14 years and on a GP Learning disability register for our primary care services • Compliance with the Trusts agreed KPI for mandatory training (KPI to be agreed) • Undertake a comprehensive review of the learning disability improvement standards for NHS trusts with any resulting action plan overseen through the EDI Committee • Engage with people with learning disabilities to ensure our services are inclusive and responsive to their needs

Care Quality Commission (CQC)

The Care Quality Commission is the independent regulator of all health and social care services in England. The CQC regulates, monitors and inspects hospitals, general practices and other care services, to make sure they provide people with safe, effective and high-quality care.

Dudley Integrated Health and Care NHS Trust is required to register with the Care Quality Commission and its current registration status is registered with no conditions attached to the registration.

The Care Quality Commission has not taken enforcement action against Dudley Integrated Health and Care NHS Trust during the period 1 April 2021 - 31 March 2022.

Dudley Integrated Health and Care NHS Trust has not participated in any national reviews or investigations by the CQC during the reporting period.

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

These are summarised on the next page.

	Safe	Effective	Caring	Responsive	Well-Led	Overall
IAPT	Good	Good	Good	Good	Good	Good
PCMHS	Good	Good	Good	Good	Good	Good
High Oak Surgery	Good	Good	Good	Good	Good	Good
School Nursing	Good	Good	Good	Good	Good	Good

During each of our phases of expansion, as services have transferred into the Trust, we have engaged with CQC and continue to do so as we plan for future developments.

Incident Reporting and Management

The Trust reports and monitors all incidents using its electronic incident reporting system, RLDatix, following its implementation at the start of this year. With support from the central Quality & Safety team and other relevant subject-matter experts, all incidents are investigated to the required level to identify any opportunities for learning and improvement.

Serious Incidents (SIs) in health care are adverse events where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.

In 2021/22, the Trust reported a total of 138 incidents of which 1 (0.7%) was classified as an SI. This incident was also the only incident reported this year that resulted in severe harm or death, relating to the suicide of a patient who had used our Primary Care Mental Health Service in the months preceding the sad event. The subsequent investigation did not identify and concerns with the care provided by the Trust but did provide an opportunity for an open and productive conversation with other relevant partners to identify any opportunities for wider system learning.

This serious incident met the threshold for Duty of Candour which was completed within the required timeframe; this was the only incident that met the threshold for Duty of Candour.

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

No Never Events have been reported during 2021/22.

Service User Experience

Understanding service user experience is important to us as this helps us to ensure that our services are developed and improved to meet service users' needs. We have systems and processes to listen and receive peoples' experiences and views, responding comprehensively to feedback and demonstrating what has been improved as a result.

Despite the impact of COVID-19, throughout 2021/22 the Trust has continued to develop its approach to patient and service user experience

aiming to further improve patient experience, engagement and public involvement.

This has included a continued focus on encouraging patients and carers to give us their views on the care they have received from us through sharing 'patient stories', many of which were presented to the Trust Board. In addition, we have implemented new processes for creating and issuing electronic surveys using a simple Microsoft Forms form. This makes it easier to provide feedback on a range of different areas; towards the end of 2021/22 we have used this system to collate feedback on the Winter Hub.

As part of a complete revision of our patient feedback policy this year, we have also engaged with a patient representative group to gain some incredibly helpful and honest feedback on the things that frustrate patients when trying to give feedback on services they have received. This has resulted in a number of changes being made to our internal processes and the creation of a single 'have your say' email address that can be used for any type of feedback.

Complaints, Compliments and Concerns

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

A total of 31 formal complaints were received by the Trust during 2021/22; this represents an increase on the previous year, largely reflective of an increased number of services being provided by the Trust as well as improving and raising the visibility of our processes for service users to raise concerns.

None of these complaints have been referred to the Parliamentary Health Service Ombudsman.

A further 20 informal concerns were received over the year; these provided further opportunities to not only learn but the address concerns of patients or their families and reassure them of any areas we can improve as a result.

We also received 47 compliments which represents a significant increase on last year; this is likely to be at least in part as a result of increasing the awareness of our staff in how to correctly capture and record compliments that they receive using our RLDatix system.

Friends & Family Test

The Friends and Family Test (FFT) is a national scheme which provides a quick and anonymous way for people who use our services to have the opportunity to provide feedback on their experience and help us identify potential improvements to what we do.

FFT is designed to be an additional feedback mechanism in addition to the formal complaints process and other forms of feedback.

Mental Health

In 2021/22, 266 service users responded to our Mental Health Services' Friends and Family test – primarily regarding the IAPT service - which asked for an overall view of their experience of our service.

99.6% of respondents felt the service was either 'good' or 'very good'.
High Oak Surgery

FFT was suspended for primary care services during 2021/22 due to the Covid pandemic.

Involving and Listening to our Workforce

As of 31st March 2022, over 350 staff work for the Trust. These are our most important resource and without their dedication we would not be able to provide the services that we do.

Our staff offer a number of specialisms and backgrounds, with many having transferred in from other organisations. In April 2021, we welcomed the Dudley School Nursing team into our organisation and have continued to add to our complement of staff working in primary care including roles such as paramedics and physician associates.

We recognise that building a culture of two-way communication, is crucial in helping to ensure that staff feel recognised and valued; to support this, the Trust promotes a culture that is based upon working openly and collaboratively and encourages staff to suggest new ways of working to ensure that we continue to provide high quality services.

Impact of Covid-19 on our Staff

Staff continued to follow the national COVID guidance that developed over the year with support from DIHC's Lead Infection Control Nurse. Many services continued to be offered remotely with the gradual reintroduction of face-to-face contact as restrictions were eased. Ongoing support is offered to staff for managing their health and wellbeing and the organisation continues to adopt agile working practices to enable flexibility for the delivery of services as well as the maintenance of staff wellbeing.

Staff Away Day

We undertook our first all staff away day in October 2021 – over 80% of staff attended and shared best practice and provided us with valuable feedback on areas we could improve upon. As a result of this feedback, we have developed a clear action plan and changed our processes for communicating with staff. We have also further strengthened our Freedom to Speak Up Guardian (FTSU) support to our staff.

Staff Survey

The 2021 NHS Staff Survey was the first time that DIHC as an entity has taken part in the national survey with an overall response rate of 63%; this compared well to a national median response rate of 61% for our benchmarking group of Community Trusts.

Questions are aligned to the People Promise which sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven core elements (see next page) plus two additional areas of scoring 'staff engagement' and 'morale':

	Compassionate and inclusive	Recognised and rewarded	A voice that counts	Safe and healthy	Always learning	Work flexibly	We are a team	Staff engagement	Morale
Best	7.9	6.7	7.3	6.4	6.2	7.0	7.3	7.4	6.3
Your org	7.6	6.7	6.9	6.4	5.4	6.8	6.9	7.0	6.2
Average	7.6	6.4	7.2	6.2	5.8	6.6	7.0	7.2	6.1
Worst	7.1	5.8	6.7	5.9	4.9	6.3	6.6	6.7	5.6

Overall, the Trust has a relatively positive set of results, and compares generally well to the average score for the peer group across most themes.

Key actions being taken forward as a result include:

- Focus groups for a range of front-line staff to discuss their views of quality of care, listening to patient concerns and how this could be improved
- The approval of the newly developed leadership framework and portfolio of development and advocate for all leaders to undertake the programme
- Ensuring that all new Trust policies, wellbeing offers and development offers are more proactively marketed by leaders

Health and Wellbeing of our Staff

The health and wellbeing of our staff remains of paramount importance to us. We have continued to develop our wellbeing offer to staff and have developed a digital brochure to ease access. We have also set up a contract in our own right for Occupational Health provision.

- Vivup Employee Scheme app, which provides advice and discounts in a number of areas including gym memberships
- Employee Assistance Programme which includes 24-hour advice line for mental health and psychological wellbeing
- Promotion of psychological wellbeing applications such as Headspace, Unmind, Sleepio and Daylight
- Access to the Black Country wellbeing hub
- A range of physical health support including promotion of the “Doing our Bit” free fitness programme for NHS staff
- Advice on nutrition, sleep, work/life balance and hydration, and access to one of our many professionals should it be required
- Creation of “ground rules” for promoting a healthy work life balance with some agreed working practices including ensuring breaks between meetings, limiting the amount and length of meetings and flexible working
- Development of an agile and flexible working policy and guidance
- Positive promotion of a hybrid working model

Engagement with Partners and Stakeholders

DIHC really values the partnerships and collaborative approach in the local area. The expertise of our partners, particularly the voluntary sector and the staff that are employed by statutory partners, has a wide reach into local communities. Below are some of the activities we have undertaken during the year.

Commissioners	• Attended local Mental Health Programme Boards • Attendance at STP/ICS meetings • Working on the development of the Dudley model of care with our system partners of the model of care • Participated in monthly Contract and Quality Review Meetings • Worked in partnership to develop services and pathways and address gaps and inconsistencies in service provision • Worked closely with CCG communications teams to support local initiatives such as the Covid-19 response, Winter Access Hub, long term plans and place-based care
GPs	• Engagement with GPs and commissioners on the development of place-based models of care in Dudley • Highlighted relevant GP information via CCG communications channels • Clinicians attend regular forums providing education and input to GP Forums • Fortnightly meetings with Primary Care Network (PCN) Clinical Directors. • PCN Clinical Director are an integral part of our monthly Primary Care Integration Committee • Maintained communication through the fortnightly Practice Bulletin and monthly engagement events
Media	• Have continued to share good news stories via press releases to local media • Responding to media enquiries in a timely fashion with local and national media outlets
Service users and the community	• A range of opportunities for engagement and involvement have taken place over the last year • Supported large events such as Tough Enough to Care – aimed at men’s mental health • Devised and hosted focussed workshops on different topics such as suicide and dementia • Supported partners with their engagement sessions such as the Council’s Connect and Share
Local NHS providers, public sector / third sector organisations	• Throughout 2021/22 we have worked closely with our NHS Provider partners to respond to COVID-19 and to continue to develop integrated pathways and the model of care in Dudley • We work with our NHS, council, voluntary sector and Healthwatch colleagues on the Dudley Partnership Board to develop services for patients. We have particularly focussed on how we develop our collective services for our children and young people. • We have an excellent relationship with Dudley Council for the Voluntary Sector and continue to develop our social prescribing services with Integrated Plus.

We have undertaken political engagement on different issues which include:

- Regular meetings with ward councillors for Pensnett and Brockmoor in relation to our practice – High Oak Surgery
- Regular attendance at the Dudley Council Health and Adult Social Care Overview and Scrutiny Committee (HASC) on a number of topics
- Regular attendance at the Health and Wellbeing Board
- Meetings with the West Midlands Combined Authority
- Meeting with the Leader of the Council
- Open door policy for MPs and Councillors to raise issues direct with our Chief Executive and Chair
- Developed the integrated care model with primary care which is supported by 40 signed integration agreements with our GP practices
- Fully integrated into our own organisation the High Oak practice, holding a direct APMS contract with the local CCG.
- Regular public events with the Dudley Healthcare Forum and Patient Opportunity Panel
- Held events with the local voluntary sector to explore ways of collaborating

Improving the Equality of Service Delivery to Different Groups

As described in our objectives, the Trust is looking to develop the organisation to be an inclusive model employer that champions equality and diversity, engages and involves existing and future staff in the development of DIHC, its culture and services.

Work is underway on our Equality and Diversity Strategy which will be published in late spring of 2022, and we have developed our Inclusion Network and Staff Forum.

The Trust recognises the importance of improved data quality and reporting to support the equality of service delivery to different groups. To support this the Trust has;

- Undertaken an audit of ethnicity coding within High Oak surgery
- Developed a series of actions to improve ethnicity recording over the coming months
- Reported the outcome of the ethnicity audit to Quality and Safety Committee
- Developed a separate performance metric for IAPT recovery for BME groups which is monitored at a committee and Board level
- Monitored the waiting list for IAPT by ethnicity group
- Set an objective to improve the accuracy of GP Learning disability registers within our primary care services

The Trust is promoting equality of service delivery in a number of ways;

- Working alongside our system partners to develop the model of integrated care for our population and undertake regular work with our public and patient groups to develop our services
- Improving access to services for people with a learning disability or autism
- An improved focus on increasing the rate of annual health checks for people over 14 years and on a GP learning disability register (national target 75%)
- Supporting the Equality Delivery System (EDS2) to support NHS commissioners and providers to deliver better outcomes for patients and communities
- Commissioned voluntary sector to work within some of our practices to support the uptake of Covid vaccinations within the BAME communities in Dudley
- Implementing services at a Primary Care Network level which cover a range of roles which seek to work with individuals on a personalised care basis and tailoring support around their needs and circumstances. These include:

  - Employing a Social Prescribing Link Worker for Migrant Communities in the Dudley and Netherton PCN – working specifically with those communities to ensure they get access to the support and services they need
  - Dementia and Frailty Link Workers – working specifically with patients who have dementia and with their carers
  - Work in partnership with colleagues from Public Health to explore perceptions of primary care in Lye with the Roma Community. Clinical Lead, Dr Steve Mann, accompanied the Roma Community Development Worker (CDW) on a walkabout in Lye to talk to local Roma residents

Workforce Performance Summary including Equality, Diversity, and Inclusion

We are building a flexible and innovative workforce that can help us to fulfil our values, improve quality of care for service users. We are passionate about the value that diversity of thinking and lived experience that helps our learning as an organisation. DIHC is committed to creating supportive and flexible working arrangements that suit the needs of its staff and service users and as such will consider all requests from applicants who wish to work flexibly.

We are committed to supporting the Equality Delivery System (EDS2) to support NHS commissioners and providers to deliver better outcomes for patients and communities. This also aims to deliver more personal, fairer and more diverse working environments for staff. The EDS2 is all about making positive differences to healthy living and working lives. We have reviewed and refreshed our EDS2 involving all stakeholders.

We recruited Ms. Billie Lam, an Associate Non-Executive Director with a specific focus on EDI. We have a well-established EDI committee and have seen significant growth in the membership of our Inclusion, Anti-racism and Allyship Staff Network.

We are currently developing our EDI Strategy and have seen significant progress against the objectives we set ourselves. Our EDI Annual Report will be published on our website.

We have been working as part of our ICS People Board, ensuring we are supporting the system wide EDI objectives, and have been proactive in supporting the development of the ICS EDI strategy, as well as ensuring we are working to deliver against the Midlands Workforce Race Equality Strategy, including monitoring ourselves against the race disparity data, and setting targets for workforce diversity growth aligned to the NHS expectations.

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

We completed our first WRES and WDES in Autumn 2021 although we had limited data. Both the data and our action plans are published on our website.

We are representative of the community we serve overall from an ethnicity perspective but recognise that we lack diversity in our senior level roles, and at board level. This is a key objective for us, and we are striving to improve this through ongoing education of our leaders in the recruitment and selection processes we use, alongside working to market roles in different ways to encourage more diverse applications.

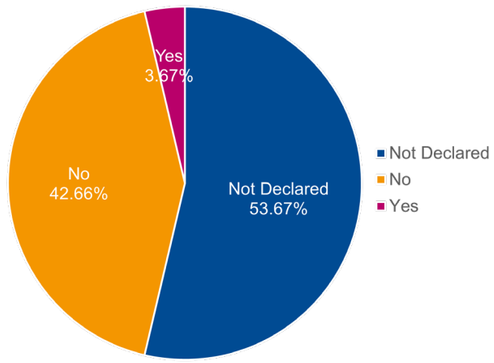
We are a Disability Confident employer and have positive systems in place for staff that we employ with disabilities, including a reasonable adjustments passport. We do, however, recognise that our workforce data is poor and have continued to encourage staff to update their ESR profiles.

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

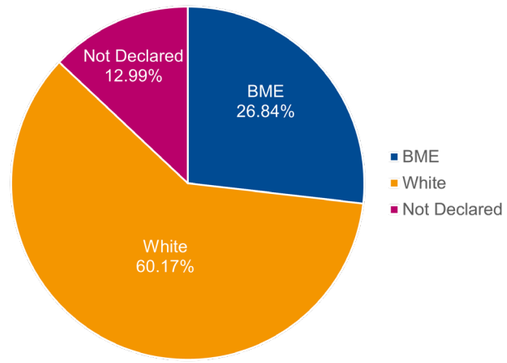
We are committed to treating everyone who visits or works for us with respect and as individuals, considering their individual differences, personal values and perspectives.

As of 31st March 2022, DIHC directly employed 354 staff (excluding non-executive directors)

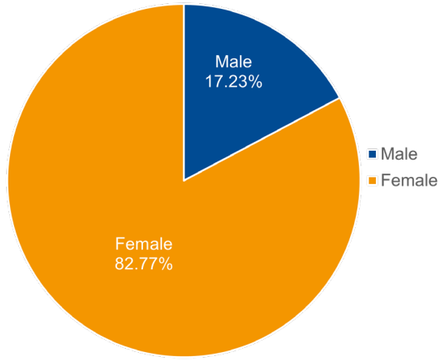
Disability



Ethnic Group



Gender



- 26.84% are from a Black, Asian, or other ethnic background (12.99% have not specified)
- 3.67% have declared a disability (53.67% have not specified)
- 0.56% have declared themselves as bi-sexual and 1.13% have declared themselves as gay or lesbian (58.19% have not specified)
- 82.77% are Female

Our Successes and Achievements

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

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

Health and Safety at Work

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

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

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

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

Incident Investigations

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

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

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

HSE Inspectors

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

Emergency Planning

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

Emergency Planning stems from the National Security Risk Assessments and the local Community Risk Register. To support these assessments, National Business Resilience Planning Assumptions set the standards we have to work to in mitigating those risks. This builds a requirement for us to produce specific emergency plans to react to incidents involving those risks.

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

DIHC is a Category 1 Responder Under the Civil Contingencies Act 2004 (CCA) . As such we are statutorily required to have appropriate emergency planning and business continuity arrangements in place.

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

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

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

Business Continuity is about maintaining our ability to deliver prioritised services during a critical incident or emergency e.g., a major security incident or an influenza pandemic. Effective Business Continuity Management is therefore about the identification, management, and mitigation of particular risks to our ability to deliver these essential services.

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

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

The BCM policy describes the strategic framework of how the Trust manages its business continuity planning. Both business continuity support and EPRR have been provided to DIHC by Black Country Healthcare NHS Foundation Trust as part of our Service Level Agreement arrangements. This has included participating in the major incident response to COVID-19.

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

A comprehensive new training and exercising programme has been created to increase knowledge and understanding of emergency planning and how key role holders within the organisation can effectively contribute to service delivery, response, and recovery during a major incident. Training will be a continual ongoing cycle of learning and will be reviewed annually. Exercising will follow a 3-year programme covering all delivery models, culminating in a live exercise in 3 years' time in line with statutory requirements.

Modern Day Slavery and Human Trafficking

The Trust is fully aware of our responsibilities towards patients, service users, employees and the local community and expects all suppliers to the Trust to adhere to the same ethical principles. The Trust is committed and will not tolerate modern slavery in any of its forms of slavery and servitude, forced or compulsory labour and human trafficking within our activities or our supply chains.

The Trust fully supports the Government's objectives to eradicate Modern Slavery and human trafficking and recognise the significant role it must play in both combatting it and supporting victims. This includes being strongly committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses.

Currently, all awarded suppliers sign up to our terms and conditions of contract which contain a provision around Good Industry Practice to ensure each supplier's commitment to anti-slavery and human trafficking in their supply chains; and that they conduct their businesses in a manner that is consistent with the Trust's stance on anti-slavery. In addition, an increasing number of suppliers are implementing the Labour Standards Assurance System (LSAS) as a condition of contract for tenders within high-risk sectors and product categories and indeed this has been referenced in the Government's Modern Slavery Strategy. Many aspects of the LSAS align to the seven reporting areas that the Government has outlined and should appear within any slavery and human trafficking statement.

People - Human resources policies provide processes and procedures to ensure that our employees and those employed in our supply chains are treated fairly at all times; these include:

- Confirming the identities of all new employees and their right to work legally in the UK.
- To have assurance from approved agencies that pre-employment clearance has been obtained for agency staff and to safeguard against human trafficking.
- All staff appointed are subject to references, immigration, and identity checks, This is to ensure staff have the legal right to work in the UK.
- The Trust has a set of values and behaviours that staff are expected to comply with and all candidates are expected to demonstrate these attributes as part of the recruitment selection process.
- Adopting the national pay, terms and conditions of service, the Trust has the assurance that all staff will be treated fairly and that pay, terms and conditions will comply with the latest legislation.
- The Trust has various employment policies and procedures in place designed to provide guidance and advice to staff and managers and also to comply with the relevant legislation. These are accessible on the intranet.
- The Trust is committed to creating and ensuring a non-discriminatory and respectful working environment for all staff. This is in line with its corporate social responsibilities.
- The Trust's Equality, Diversity and Inclusion, and Whistleblowing policies and procedures additionally give all employees the Freedom to Speak Up and to raise concerns about poor working practices.
- The Trust operates a Freedom to Speak Up Guardian and a Raising Concerns at Work Policy, so employees feel empowered to raise concerns around poor practices, health and safety or illegal activities which may bring harm to the Trust.

Equality Act (2010)

DIHC acknowledges and fully complies with its responsibilities to adhere to the Equality Act (2010):

- 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.

Counter Fraud, Bribery and Corruption

We are committed to ensuring NHS resources are appropriately protected from fraud, bribery and corruption and follow the national NHS counter fraud strategy.

As of April 2021, the Government Functional Standard 013: Counter Fraud replaced the previous NHS specific Standards for Fraud, Bribery and Corruption. Together with stakeholders across the UK, the NHSCFA have developed new NHS Requirements to meet the Counter Fraud Functional Standard. The Trust has transitioned to the Government Functional Standard for Fraud, Bribery and Corruption introduced by the Cabinet Office to help ensure consistency of approach across the public sector.

As an NHS Provider the Trust ensures that NHS funds and resources are safeguarded against those minded committing fraud, bribery or corruption. Failure to do so, impacts on our ability to deliver services and treatment, as NHS funds and resources are wrongfully diverted from patient care.

In order to reduce economic crime against the NHS, the Trust's Local Counter Fraud Specialist (LCFS) takes a multi-faceted approach that is both proactive and reactive. The Trust and LCFS will adopt the new components of the Functional Standard and will continue to follow the four key principles which are recognised to minimise the incidence of economic crime against the NHS and to deal effectively with those who commit economic crime.

The four key principles are:

1. **Strategic Governance** - this standard sets out the standards in relation to the organisation's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation.
2. **Inform and involve** those who work for, or use the NHS, about economic crime and how to tackle it. NHS staff and the public should be informed and involved to increase everyone's understanding of the impact of economic crime against the NHS. This takes place through communications and promotion such as face to face counter fraud presentations, public awareness campaigns and media management. The LCFS presents as part of the Trust induction. Working relationships with stakeholders are strengthened and maintained through active engagement.
3. **Prevent and deter** economic crime in the NHS to take away the opportunity for crime to occur or to re-occur and discourage those individuals who may be tempted to commit economic crime. Successes are publicised internally during counter fraud presentations and using other media opportunities so that the risk and consequences of detection are clear to potential offenders. Those individuals who are not deterred should be prevented from committing economic crime by robust systems, which will be put in place in line with policy, standards, and guidance.
4. **Hold to account** those who have committed economic crime against the NHS. All allegations of fraud, bribery and corruption will be investigated professionally and in line with relevant legislation, as per the counter fraud functional standard (GovS013). The Trust's LCFS is a professionally accredited investigator and is qualified to the required standards. Once allegations of suspected economic crime are received by the Trust, the LCFS must ensure that investigations are undertaken to satisfy national legislation. .

The Trust encourages the prosecution of offenders and where appropriate refers offenders to their professional bodies for disciplinary sanction. Economic crimes must be detected and investigated, suspects prosecuted where appropriate and other methods of redress sought where possible. Where necessary and appropriate, economic crime, investigation and prosecution will take place locally wherever possible. Nevertheless, the LCFS also works in partnership with the police and other crime prevention agencies to take investigations forward to criminal prosecution

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

Signed _____

Penny Harris - Chief Executive Officer
Date: 22nd June 2022

Accountability Report

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

The Accountability report has three elements:

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

Corporate Governance Report

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

- The Directors' Report
- The Statement of the Chief Executive's Responsibilities
- The Annual Governance Statement

The Directors' Report

The Trust Board

Accountable to the Secretary of State, the Trust Board is a unitary board and is responsible for the effective direction of the affairs of the Trust, setting the strategic direction, vision and values, risk appetite, monitoring performance against objectives, ensuring high standards of corporate governance and helps to promote links between the trust and local community.

The Board establishes arrangements for effective governance and management as well as holding management to account for delivery, with particular emphasis on the safety and quality of the Trust's services and achievement of the required financial performance as outlined in its Terms of Reference.

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

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

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

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

The Directors of the Trust

The Appointment and Remuneration committee help to identify the skills, qualifications and experience required for new appointments and consider the diversity of the Board's composition as a part of its recruitment process.

During the year 2021/22 the Trust Board comprised of a Chair, five other Non-executive Directors (including a Deputy Chair and a Senior Independent Director (SID)), three Associate Non-Executive Directors, five Executive Directors, and two Joint Medical Directors.

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

Non-executive Directors

Our Non-executive Directors work alongside other Executive Directors as equal members of the Board, sharing responsibility for decision making and hold the executive team accountable for strategy development. Non-executive Directors positively impact the trust with their independent judgement, external skills, specialist experience and ideas to help lead improvements in healthcare for patients and services to the community.
All Board members have been assessed against the requirements for the fit and proper persons test and together they bring a wide range of skills and experience to the Trust enabling us to

achieve balance at the highest level. The structure is statutorily compliant and considered to be appropriate.

The composition, balance of skills and experience of the Board is reviewed annually by the Appointment and Remuneration Committee.

Board of Directors who occupied positions during the year 2021/22	
Executive Directors	**Non-Executive Directors**
• *Penny Harris – Interim CEO (from 1st Jan 2022) • **Paul Assinder - Interim CEO (to 31st Dec 2021) • *Philip King - Chief Operating Officer (from 1st November 2021) • *Stephanie Cartwright - Director of Strategy, People and Partnerships (from 3rd Sep 2021 - previously Director of Strategy, Operations and Partnerships) • Mathew Gamage - Interim Director of Finance, Performance & Digital (Secondment from CCG) • *Sue Nicholls - Director of Nursing, Quality and AHPs (from 1st November 2021) • **Caroline Brunt - Interim Director of Nursing, AHPs and Quality (to 31st July 2021) • Dr Lucy Martin – Acting Joint Medical Director • Dr Richard Bramble - Acting Joint Medical Director	• Harry Turner – Chair • Ian Buckley (SID and Deputy Chair) • Martin Evans • David Gilburt • Valerie Little • Dr George Solomon **Associate Non-Executive Directors** • *Billie Lam (from 1st Jul 2021) • Dr Gillian Love • Dr Stephen Cartwright

**Appointment during the year*

***Leaver during the year*

Note: Associate Non-Executive Directors and the Chief Operating Officer do not have voting rights

Board Membership

Non-Executive Directors	
 **Harry Turner,** **Chair** Appointed on 1st April 2020 **Board Attendance 2021-22: 11/11** Chair of: • Trust Board Member of: • Trust Board Appointment and Remuneration Committee • Transaction & Transformation Committee • Audit & Risk Committee	Harry has extensive experience, having served as a Non-Executive Director and then Chairman of Worcestershire Acute NHS Trust between 2008 and 2016. He also took up the position of Chairman of the John Taylor Hospice in Birmingham October 2016 and was also a Non-Executive Director on Dudley and Walsall Mental Health NHS Trust. Harry has also been a Justice of the Peace in Worcestershire Courts for more than a decade. He previously worked as an operations Director in the hotel industry, working for businesses including Travel Inn and Marriott International. Declaration of interests: • Chair – The Hospice Charity Partnership • Chair – The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust • Presiding Magistrate Worcestershire

Non-Executive Directors

Ian Buckley,
Deputy Chair and Senior Independent Director

Appointed on 1st April 2020

Board Attendance 2021-22: 10/11

Chair of:
- Finance, Performance and Digital Committee

Member of:
- Trust Board Appointment and Remuneration Committee
- Quality and Safety Committee
- Transaction & Transformation Committee
- Primary Care Integration Committee

Ian has worked as Chief executive for several UK and US businesses and served on both PLC and private company boards.

He trained as an engineer in Birmingham, moved into finance and leasing and became the UK Chief Executive of the US leasing giant GELCO (Now a division of GE).

He was part of the management buyout and the subsequent public flotation at Evans Halshaw PLC serving as a main board director.

In 1999 he joined Advanced Communication and Information Systems (ACIS) as CEO, a venture capital backed, telematics business specialising in providing real time passenger information for, airports, buses and trams. Whilst there, ACIS were awarded the Queens Award for Innovation.

He was Deputy Chair and Non-Executive Director of Birmingham Community Healthcare NHS Trust and Vice Chair of University Hospitals Coventry and Warwickshire NHS Foundation Trust.

Currently he is a Business Angel investor, business coach and facilitator for Leadership Trust and guest lectures at Bristol Business School.

Declaration of interests:
- None declared for 2021/22

Non-Executive Directors

David Gilburt,
Non-Executive Director

Appointed on 1st April 2020

Board Attendance 2021-22: 8/11

Chair of:
- Audit and Risk Committee

Member of:
- Trust Board Appointment and Remuneration Committee
- Finance, Performance and Digital Committee

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

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

Declaration of interests:
- Associate Non-Executive at Robert Jones Orthopaedic Hospital
- Cheshire Police Audit Committee Member
- Muir Group Housing Association Audit Committee Member

Non-Executive Directors

Valerie Little,
Non-Executive Director

Appointed on 1st April 2020

Board Attendance 2021-22: 11/11

Chair of:
- Quality and Safety Committee

Member of:
- Trust Board Appointment and Remuneration Committee
- Audit and Risk Committee
- Transaction & Transformation Committee
- People Committee

Valerie was born and brought up in Dudley, attending school in the Borough. She has studied both science and social science at Bristol, LSE and Birmingham Universities.

She worked for the NHS for 40 years – 18 of these as an Executive Director, finishing with 12 years as a Director of Public Health in Dudley. She is a Fellow of the Faculty of Public Health (FPH).

She has served on the FPH Health Protection Committee and Housing Special Interest Group, as well as having acted as an FPH professional assessor. She served on the Executive Committee of the Association of Directors of Public Health, taking a lead on sexual health services. Over the years she has developed particular interests in health and regeneration; and the role that the Arts can play in health. Since retiring from full-time employment she has undertaken some independent public health work but now devotes time to her role as Vice Chair of the Corporation of Dudley College of Technology and to the issue of housing for older people.

Valerie is both a resident and patient in the Borough.

Declaration of interests:
- Member of the Corporation of Dudley College of Technology
- Member of the Board of Care & Repair England (ceased May 2022)

Non-Executive Directors

Dr George Solomon,
Non-Executive Director

Appointed on 1st April 2020

Board Attendance 2021-22: 8/11

Chair of:
- Primary Care Integration Committee

Member of:
- Trust Board Appointment and Remuneration Committee
- Primary Care Integration Committee
- People Committee
- Quality & Safety Committee

Dr George Solomon is a retired GP who worked in general practice for thirty-one years. He graduated from Glasgow University in 1978 and worked in Junior Doctor posts in Glasgow and Somerset.

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

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

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

Declaration of interests:
- Partner is a Non-Executive Director of Walsall Healthcare NHS Trust
- Volunteer COVID Vaccinator SWL PCN, Dudley

Non-Executive Directors

Martin Evans,
Non-Executive Director

Appointed on 1st April 2020

Board Attendance 2021-22: 11/11

Chair of:
- People Committee

Member of:
- Trust Board Appointment and Remuneration Committee
- Audit and Risk Committee
- Finance, Performance and Digital Committee
- Transaction & Transformation Committee

Martin has worked within the public sector for over 30 years and has recently retired from the Police Service where he served latterly as an Assistant Chief Constable with West Mercia Police having responsibility for delivery of 24/7 policing services across the counties of Shropshire, Telford, Worcestershire and Herefordshire.

Martin was the national policing lead for Collision Investigation and led on many developments and operations both nationally and across Europe in relation to roads policing, targeting travelling organised criminals whilst at the same time striving to make our roads safer and reduce the number of people killed and seriously injured.

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

Martin is a people person, having previously and continuing to support others in a coaching and mentoring capacity and he is a great believer in wanting and needing to ensure that we do all that we can to look after and support our staff.

Declaration of interests:
- None declared for 2021/22

Associate Non-Executive Directors

Billie Lam,
Associate Non-Executive Director

Appointed on 1st July 2021

Chair of:
- Equality, Diversity, and Inclusion Committee

Member of:
- Trust Board Appointments and Remuneration Committee
- People Committee
- Transaction & Transformation Committee

Billie brings a vast amount of experience of over thirty years, as a qualified nurse and a senior leader in NHS and independent organisations. Her work involves in addressing a diverse range of quality and patient safety issues at both operational and strategic levels. She has worked in a variety of settings, including acute, community and commissioning.

Billie values education and continuous professional development and is an alumnus of the NHSEI Non-Executive Director Training Scheme.

She was born and brought up in Hong Kong, before coming to the UK for further education. Having been exposed to different cultures and worked with people from varied backgrounds, she is committed to equality, diversity, and inclusion.

Declaration of interests:
- Volunteering for Staffordshire Healthwatch
- Registered as a bank staff at Kettering General Hospital NHS Foundation Trust
- Member of Seacole Group
- Attending Inclusion Council and North Staffordshire ICP Stakeholder Group meetings at North Staffordshire Combined HC Trust

Associate Non-Executive Directors

Gillian Love,
Associate Non-Executive Director

Appointed on 1st April 2020

Member of:
- Quality & Safety Committee
- Primary Care Integration Committee
- Trust Board Appointments and Remuneration Committee
- Transaction & Transformation Committee

Dr Gillian Love was locally educated in Kinver and Stourbridge and qualified from medical school in Birmingham in 1991.

She has been a partner at Halesowen medical practice since 1996 having worked in Dudley Group hospital posts and local practices whilst training to be a GP.

Gillian was a Clinical Assistant in Russell's Hall A&E in her earlier GP years and later, worked for 8 years as a Staff grade doctor at Mary Stevens Hospice in Stourbridge alongside her General Practice role.

She has been a GP trainer for almost 20 years and is passionate about the promoting place of Primary and Community care in the health and wellbeing of our population.

Gillian became involved in representing her primary care colleagues in the development of Dudley's integrated care model.

Gillian is also Clinical Director of Halesowen PCN .

Declaration of interests:
- GP Partner Halesowen Medical Practice
- Clinical Director of Halesowen PCN
- Director of Future Proof Health
- Share Holder of Future Proof Health
- Director of Mary Martin Enterprise Ltd

Associate Non-Executive Directors

Stephen Cartwright,
Associate Non-Executive Director

Appointed on 1st April 2020

Member of:
- Transaction & Transformation Committee
- Trust Board Appointments and Remuneration Committee

Stephen has worked as a GP for 35 years with 30 of those years in Dudley.

Born and educated in the Black Country he has worked as a Medical Director in the West Midlands for part of his career.

He is passionate about developing integrated patient centred care and working more closely with the local acute trust to deliver that.

He has always been a keen sportsman and can now often be seen road biking on the local roads.

Declaration of interests:
- Partner GP - Keelinge House Surgery
- Part owner of Keelinge House Building
- Shareholder of Future Proof Health

Executive Directors

Penny Harris,
Interim Chief Executive Officer

Appointed on 1st January 2022

Board Attendance 2021-22: 3/3

Attendee of:
- Trust Board Appointments and Remuneration Committee
- Audit & Risk Committee
- Trust Management Board

Penny has more than 25 years' experience working at Board level in the NHS. She has extensive experience of working in and alongside the NHS and social care sectors at a very senior level including several Chief Executive Officer positions.

Her portfolio has included implementing models to integrate health and social services and more latterly strategic planning, system management and delivery in support of Integrated Care Systems (ICS).

An Accredited CEDR mediator, Penny also provides mediation, management consultancy and executive coaching. Penny has extensive experience in public engagement and public participation.

Penny joined DIHC as Interim CEO in January 2022 and is an active partner in the Integrated Care System in the Black Country and West Birmingham.

Declaration of interests:
- Director of Kerr Darnley Ltd
- Specialist Consultant for PwC

Executive Directors

Philip King,
Chief Operating Officer

Appointed on 1st November 2021

Board Attendance 2021-22: 7/7

Attendee of:
- Quality & Safety Committee
- Finance, Performance and Digital Committee
- Primary Care Integration Committee
- People Committee
- Trust Management Board

Philip has over 30 years' experience within Health and Social Care. He has held a number of long term interim Executive Director roles within provider, commissioner, and regulatory organisations, in the NHS and within the commercial sector.

He focusses on working with organisations during transformation processes. His provider experience is within community, primary care, mental health, LD, and acute provision. He was previously a Director within the Care Quality Commission.

He has a twin professional background as both a nurse and a Barrister. His clinical expertise is within the fields of mental health, learning disability and autism, and acquired brain injury. He advised the Law Society on Equality, Disability and Mental Health Law and was one of the legal team that took a key case to the European Court of Human Rights to decide issues in relation to Mental Capacity (HL v the United Kingdom).

He is a visiting lawyer at Birkbeck School of Law, University of London, a college which specialises in providing degree and post graduate education for mature students, often without previous formal educational qualifications. Philip is himself a graduate of their programme. He continues his NMC registration, and he also has an MSc from United Medical and Dental Schools (now Kings College), London in Mental Health.

Outside of work Philip and his husband look after six alpacas, a dozen rare breed sheep, three competition horses, a flock of rescued chickens and a whippet.

Declaration of interests:
- Visiting lawyer and lecturer, Birkbeck School of Law, University of London
- Member of Liberty Lawyers Group
- Member of The Inner Temple
- Registrant Member of the Bar of England and Wales
- Member of the Royal College of Nursing
- Director of Audenmark Ltd

Executive Directors

Stephanie Cartwright, Director of Strategy, People and Partnerships and Deputy Chief Executive

Appointed on 1st April 2020

Board Attendance 2021-22: 11/11

Attendee of:

- Trust Board Appointments and Remuneration Committee
- Transaction & Transformation Committee
- Primary Care Integration Committee
- People Committee
- Equality, Diversion and Inclusion Committee
- Trust Management Board

Stephanie has responsibility for the development of our organisational strategies, people and managing our relationships with partners and stakeholders. Stephanie has over 25 years' experience of working with the Health Service.

Her professional background is in organisational development, management and leadership and she has held a Board level role for 8 years.

For the last 5 years, Stephanie has been involved in the development of the ICP new care model in Dudley as the Programme Director, and more latterly as the Interim Managing Director for the ICP development; a role she has undertaken for the last 18 months.

Stephanie is passionate about the transformational change that the ICP will bring to the way health and care services are delivered in Dudley and the opportunities that it will bring for both patients and staff alike.

Declaration of interests:

- Married to the Chief Executive Officer of Black Country and West Birmingham CCGs who was in post until 31st March 2022.

Executive Directors

Matthew Gamage, Interim Director of Finance, Performance and Digital

Appointed on 1st April 2020

Board Attendance 2021-22: 10/11

Attendee of:

- Audit and Risk Committee
- Finance, Performance and Digital Committee
- Transaction & Transformation Committee
- Trust Management Board

Matt is responsible for the financial management of the Trust, as well as leading on contracting, performance and digital.

He is named as the Senior Information Risk Owner.

Matt is local resident with over 25 years' experience in NHS Finance. In his previous role at Dudley CCG, he led on the financial development of the Integrated Community Provider (ICP) and the new ICP contract.

Declaration of interests:

- CIMA Member
- Currently seconded to Interim Director of Finance role from Dudley CCG

Executive Directors

Sue Nicholls,
Interim Director of Nursing and AHPs

Appointed on 1st November 2021

Board Attendance 2021-22: 6/7

Attendee of:
- Quality and Safety Committee
- Primary Care Integration Committee
- People Committee
- Equality, Diversity and Inclusion Committee
- Audit & Risk Committee
- Trust Management Board

Sue is an experienced nurse leader who has held roles at Board and Sub-Board level.

After qualifying in 1996 she has worked across several clinical roles to include acute medicine, palliative care and respiratory services.

Sue has worked within the independent sector and the NHS in the field of clinical quality and safety and is the executive lead for the Trusts safeguarding and infection prevention agenda.

She continues to maintain her clinical practice in order to ensure an understanding of frontline issues and the experience of staff and our patients/service users.

Sue undertakes post registration teaching at a local university providing sessions on clinical leadership and quality improvement.

Declaration of interests:
- Sessional Lecturer, Birmingham City University
- Governor Arrow Vale School Redditch
- Clinical practice – Hampton in Arden Surgery. Solihull

Executive Directors

Dr Lucy Martin,
Joint Medical Director

Appointed on 1st April 2021

Board Attendance 2021-22: 5/11

Member of:
- Quality & Safety Committee
- Primary Care Integration Committee
- People Committee
- Equality, Diversity and Inclusion Committee
- Audit & Risk Committee
- Trust Management Board

Lucy was born and raised in Dudley, and after time away at the University of Manchester medical school, graduating in 1996 returned to live and work in the borough. She trained in Wordsley, Russells Hall and Bushey Fields Hospitals and GP surgeries in Kingswinford and Tipton. She became a GP partner at Eve Hill Medical Practice in Dudley in 2001, where she has worked ever since as a partner and GP trainer for the Dudley GP Vocational Training Scheme.

Also, in 2001 Lucy joined Mary Stevens Hospice in Stourbridge, working as a doctor on the in-patient unit from 2001 until 2006, then undertaking a Post-graduate Diploma in Palliative Medicine from Cardiff University. She then became Medical Director of the hospice, remaining in that post until leaving in 2019. Working in the hospice and sharing their philosophy about the importance about caring for patients who have symptoms from advanced disease, or who are in the last year of their lives strongly influenced Lucy's career, and she took on the job of Macmillan GP Facilitator and Clinical Lead for Cancer and End of Life Care for Dudley in 2012, transferring to Dudley Integrated Health & Care NHS Trust in October 2020.

These roles have involved working together with partners across the health economy, including primary, secondary and third sector organisations, locally, regionally and nationally.

Lucy studied for an MSc in Medical Leadership (distinction) from Birkbeck, University of London and following this was appointed to the Associate Medical Director role for DIHC. She continues to work as a GP partner at Eve Hill alongside this role.

Declaration of interests:
- Partner Eve Hill Medical Practice
- Shareholder Futureproof Health
- Board member Stourbridge Lawn Tennis and Squash Club

Executive Directors

Dr Richard Bramble,
Joint Medical Director

Appointed on 1st April 2021

Board Attendance 2021-22: 4/11

Member of:
- Primary Care Integration Committee
- Quality & Safety Committee
- Audit & Risk Committee
- People Committee
- Equality, Diversity and Inclusion Committee
- Trust Management Board

As a Dudley GP, Richard has chosen to walk alongside some of our most deprived communities and has been striving to reduce inequalities.

This has taken the form of partnership working with local community groups and the council to create projects that improve access to exercise, reduce childhood obesity and beat social isolation. Richard previously spent seven years working in shanty towns in Yemen and still holds a strong interest in removing the barriers between groups of different belief or ethnicity.

Richard has been on the DIHC journey since its inception, both as a former CCG Clinical Lead and, more recently, as a Primary Care Network Clinical Director. His hope is to see lives and communities transformed through more holistic, joined-up health and social care.

Declaration of interests:
- GP Partner, Links Medical Practice
- Shareholder, Futureproof Health
- Revival Fires Church

Directorships During the Year

Executive Directors

Paul Assinder,
Chief Executive

From 1st April 2020- 31st December 2021

Board Attendance 2021-22: 7/8

Attendee of:
- Quality and Safety Committee
- Finance, Performance and Digital Committee
- Transaction Committee
- Trust Board Appointment and Remuneration Committee

Paul was responsible for delivering the strategic and operational plans of the Trust through the Executive Team.

He was elected as National President of the Healthcare Financial Management Association (HFMA), the leading professional body for finance staff working in UK healthcare, in December 2009.

Doubly qualified as an accountant, with a university background in both economics and management, he trained and worked with Ernst & Young Co in the UK after graduation before specialising in the healthcare and technology sectors.

Executive Directors

Caroline Brunt,
Interim Director of Nursing, Allied Health Professionals (AHPs) and Quality

From 1st April 2020 to 31st July 2021

Board Attendance 2021-22: 4/4

Attendee of:

- Quality and Safety Committee
- Transaction Committee
- Primary Care Integration Committee
- People Committee

Caroline was responsible for the professional standards, education and development of nursing and allied health professionals and leads on clinical governance.

She was also the Lead Executive responsible for service user and public engagement, safeguarding and infection, prevention, and control.

Caroline commenced training as a nurse at the Queen Elizabeth Hospital, Edgbaston, Birmingham in 1981, registering in 1984. She subsequently qualified as a midwife in 1986 and has since continued her service in the NHS as a nurse/midwife working in a range of clinical and managerial roles throughout her career. She holds an NMC registration on both the adult nursing and midwifery registers. She also holds an MSc (Distinction) in Leadership and Management in Health and Social Care from the University of Southampton.

Caroline has held senior clinical leadership posts prior to joining Dudley Clinical Commissioning Group (CCG) as Chief Nurse in November 2015. She led the Quality and Safety team and the Safeguarding team; working together to ensure that DIHC meets its statutory responsibilities associated with the provision of safe, high quality patient services across the borough of Dudley. Caroline has also led the CCG Primary Care Commissioning team with oversight of the Primary Care core contracting and commissioning function.

Other Directors and persons attending Board regularly during 2021/22

- Elaine Doyle, Trust Secretary from 1st January 2021: Attended 9 out of 11 Board meetings in 2021/22.
- James Young, Associate Director of Governance and Quality: Attended 8 out of 11 Board meetings in 2021/22.
- Bev Edgar, Associate Director of People: Attended 7 out of 11 Board meetings in 2021/22.

Attendance by Members of Board Committees in 2021/22

The below figures indicate the number of meetings attended by the relevant member/total number of meetings held during 2021/22, this is for the principal assurance committees of the Board.

Board Member	Trust Board Part 1 (Public session)	Trust Board Part 2 (Pvt Session)	Audit and Risk Committee	Appoint-ments and Remu-neration Commit-tee	Quality and Safety Committee	Finance, Perfor-mance and Digital Commit-tee	People Committee
Harry Turner	10/10 (100%)	11/11 (100%)	1/1 (100%	9/9 (100%)			
Ian Buckley	10/10 (100%)	10/11 (90.9%)		8/9 (88.8%)	9/10 (90%)	11/11 (100%)	
David Gilburt	8/10 (80%)	8/11 (72.7%)	6/6 (100%)	8/9 (88.8%)		7/11 (63.6%)	
Valerie Little	10/10 (100%)	11/11 (100%)	6/6 (100%)	7/9 (77.7%)	10/10 (100%)		9/11 (81.8%)
Dr George Solomon	7/10 (70%)	8/11 (72.7%)		6/9 (66.6%)	9/10 (90%)		9/11 (81.8%)
Martin Evans	10/10 (100%)	11/11 (100%)	6/6 (100%)	4/9 (44.4%)		9/11 (81.8%)	11/11 (100%)
Dr Richard Bramble*	4/10 (40%)	4/11 (36.4%)					
Stephanie Cartwright	10/10 (100%)	100 (100%)			8/10 (80%	10/11 (90.9%)	11/11 (100%)
Matt Gamage	9/10 (90%)	10/11 (90.9%)	6/6 (100%)			11/11 (100%)	8/11 (72.7%)
Penny Harris	3/3 (100%)	3/3 (100%)		2/2 (100%)			
Philip King	6/6 (100%)	7/7 (100%)			4/5 (80%)	4/5 (80%)	3/3 (100%)
Dr Lucy Martin*	4/10 (40%)	5/11 (45.5)			9/10 (90%)		5/11 (45.5%)
Sue Nicholls	6/6 (100%)	6/7 (85.7%)			7/10 (70%)		5/11 (45.5)
Paul Assinder	7/8 (87.5%)	7/8 (87.5%)	3/3 (100%)	4/4 (100%)	5/8 (62.5%)	3/8 (37.5%)	
Caroline Brunt	4/4 (100%)	4/4 (100%)			4/4 (100%		2/3 (66.6)

Note: Joint Medical Directors are job sharing

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
- 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 _____

Penny Harris - Chief Executive Officer
Date: 22nd June 2022

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 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
- 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 and knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

Signed _____

Penny Harris - Chief Executive Officer
Date: 22nd June 2022

Signed _____

Matthew Gamage - Finance Director
Date: 22nd June 2022

Annual Government Statement

Scope of Responsibility

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

Working in Partnership with the Wider System

Dudley Integrated Health and Care NHS Trust is proud to join 14 other health and care organisations as part of the Healthier Futures Integrated Care System (ICS) serving the 1.5 million people in the Black Country and West Birmingham. Working with other key partners, people and communities, the partnership aims to improve the health and wellbeing of local people by working together to:

1. improve the health of our population by reducing inequalities in health outcomes and improving the quality of and access to services
2. 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
3. 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

During the last 12 months the partnership has played a key role in responding to COVID-19 and our focus now shifts to supporting our communities, staff and the wider system of health and care to recover from it.

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Dudley Integrated Health and Care NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

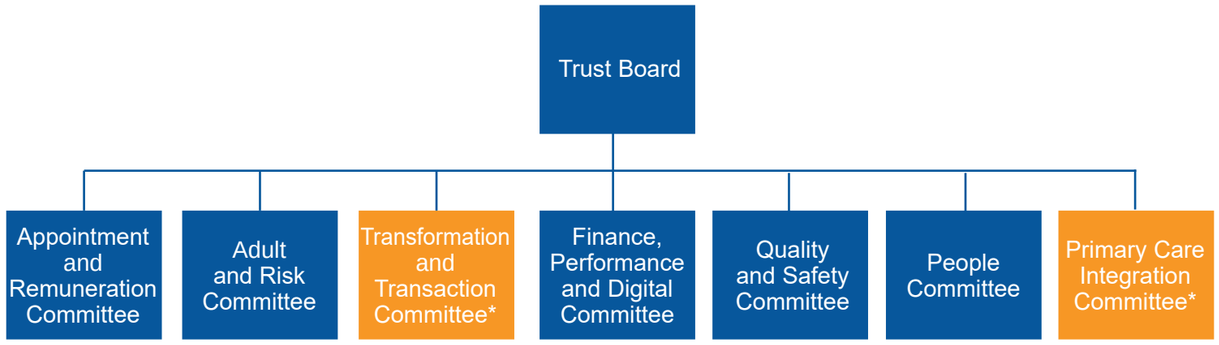
The system of internal control has been in place in Dudley Integrated Health and Care NHS Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

The Integrated Governance Framework

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.

On 31st March 2022, the DIHC Board Committee Structure was as described below, with the principal assurance committees of the Board being Audit and Risk, Appointments and Remuneration, Quality and Safety, Finance, Performance and Digital and the People.

The assurance committees are constituted to ensure the delegated operation of effective risk management systems and processes and these committees inform and assure the Trust Board through reporting and creation of working groups as defined within their terms of reference.



**not formal assurance committees*

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

Trust Board

The Trust Board met ten times in public session, conducting meetings virtually, however, reverted to in person face to face meetings from September 2021 following the relaxation of the pandemic restrictions. Other than for matters requiring commercial confidence, it has conducted its business in public and ensured that access to both virtual and in person meetings to Board meetings held in public session were made available to the 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 Chair's term of office commenced from April 2020 for a three-year term. On 31st March 2022, the Board comprised four female and three male Executive Directors; and three female and six male Non- Executive and Associate Non-Executive Directors; one from a minority ethnic background.

At each meeting, the Trust Board considered reports on:

- Chair's Report
- Report of the Chief Executive Officer
- Board Assurance Framework and Corporate Risk Register
- Report from the Medical Director
- Report from the Director of Nursing, AHPs and Quality
- Quality and Safety Performance Report
- Quality and Safety Committee Assurance Report
- Workforce Performance Report
- People Committee Assurance Report
- Equality, Diversity, and Inclusion Assurance Report
- Finance, Performance and Digital Report
- Finance, Performance and Digital Committee Assurance Report
- Report from the Primary Care Integration Committee
- Report from the Transaction and Transformation Committee

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.

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. The NEDs are committed to self-development and learning, as evidenced by virtual attendance at events arranged by NHS England Improvement (NHSEI), 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).

Throughout the COVID-19 pandemic, the Board and Board Committee's, development sessions and briefings have continued as planned via 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.

The Non-Executive Directors (NED) are committed to self-development and learning, as evidenced by virtual attendance at events arranged by NHS England Improvement (NHSEI), NHS Providers, Healthcare Financial Management Associate (HFMA) NED forum, Chair and NED events put on by the Health Services Management Centre and the Good Governance Institute.

Board Effectiveness

The Board of Directors keeps its performance and effectiveness under on-going review. During the year there have been substantive appointments and reappointments to strengthen the effectiveness of the Board. The Board holds seminar and workshops every month to focus on educational, developmental, and strategic topics. The cycle of business and terms of reference for the Trust Board and its committees has been updated and the action tracker continues to track completion of the actions identified.

An annual review of committee effectiveness was undertaken, and the principal assurance committees assessed their performance, reviewed the terms of reference and cycle of business with results reported through to the Trust Board, in public session.

Audit and Risk Committee

Non-Executive Members: Chair - Mr. D Gilburt, Ms. Valerie Little and Mr. Martin Evans

Committee Self-Assessment Rating: Strong

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

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

During the year, the committee received and discussed reports on the:

- Annual Report and Accounts
- Board Assurance Framework, Corporate Risk Register, and related governance processes
- Finance and Performance Report
- Waiver Review
- Internal and External Audit reports
- Freedom To Speak Up
- Counter Fraud Investigations
- Programme for Policy Review

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 the counter fraud work plan and oversees when fraud is suspected to ensure incidents are fully investigated. The committee seeks assurance that appropriate action has been taken, which can result in criminal, disciplinary and civil sanctions being applied, which includes referrals to professional regulatory bodies were appropriate.

There were no significant frauds detected during the year, although one incident reported was investigated although no fraud was found.

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

External Audit Services

Our External Auditors are Grant Thornton UK LLP, 17th Floor, 103 Colmore Row, Birmingham, West Midlands, B3 3AG

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

External Audit is required to review and report on:

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

The Audit and Risk Committee reviews the external audit annual audit plan at the start of the financial year and receives regular updates on progress. Expenditure recognised with Grant Thornton UK LLP for the period for was £122,000, of which £90,000 was wholly in respect of the statutory financial statements audit for 2021/22. Our external auditors did not conduct any non-audit services in year. The additional fees related to audit services for 2020/21.

Internal Audit Services

Our Internal Auditors during 2021/22 were CWAudit. Internal Audit provides an independent assurance with regards to our systems of internal control to the Board.

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

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

The cost of the internal audit provision for 2021/22 was £51,200.

Quality and Safety Committee

Non-Executive Members: Chair – Ms. Valerie Little, Mr. Ian Buckley and Dr George Solomon

Committee Self-Assessment Rating: Adequate to Strong

Frequency of meeting: The Committee met ten (10) times during the year.

The aims of the committee are to provide assurance to the Board about the effectiveness of quality governance structures, systems, processes and controls, adherence to current and future statutory and mandatory quality standards, such as Care Quality Commission (CQC), mechanisms used for the involvement of patients and public, staff, partners and other stakeholders in improving quality assurance and patient safety, undertaking responsibilities outlined in the Mental Health Capacity act and oversee safeguarding arrangements for Safeguarding Children, Looked After Children and Safeguarding Adults, 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.

During the year, the committee received and discussed reports on the:

- Board Assurance Framework and Corporate Risk Register
- Vaccination Centre Serious Incident Reporting
- Quality Accounts Update
- Quality and Safety Performance Report
- Safeguarding and Supervision report
- Quality Objectives 2021-22 –progress report
- Clinical Governance development and due diligence

The Committee receives reports from the Chair of the Quality and Safety Steering Group (QSSG) and the minutes of these meetings, which provide assurance through detailed reviews of compliance and risk.

In addition to policy development, the Committee also ensures safe landing of services into the Trust through assurance from the quality impact assessment and clinical due diligence processes.

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

Finance, Performance and Digital Committee

Non Executive Members: Chair – Mr. Ian Buckley, Mr. Martin Evans and Mr. David Gilburt

Committee Self-Assessment Rating: Strong

Frequency of meeting: The Committee met eleven (11) times during the year.

The aims of the committee are to provide the Trust Board with assurance on the delivery of the financial aspects of the Trust's annual Operating Plan, including financial strategy and planning, transformation and sustainability, the financial performance of the Trust, and on commercial and procurement activity and contracts, strategic investments, and the development of the Trust's digital and estates infrastructure. It also supports the development, implementation, and delivery of the Financial Plan and the efficient use of financial resources to review the Trusts' financial strategy, exposure to financial risk, performance and business development.

The committee met monthly and considered in detail:

- Trust's financial position
- Strategies and Policies including Digital, Finance, Estates and Commercial Strategy alongside the Capital Expenditure Programme and Investment Policy
- Annual Plan and Budget Setting
- Future Income via Business Cases and Tender Submissions and Commercial Development Opportunities
- Progress and Performance against the approved Green Plan

The Digital Board and the Information Governance Group reports into the Committee. During the year, the committee oversighted the Digital Strategy and Programme of Work, including implementation of EMIS, IT policy development and the safe landing of services including School Nursing Service and Practice Based Pharmacist and has been in receipt of assurance reports from the work of the Digital Board. The Digital Strategy Plan was revised based on three priorities; Partnership working and Integration, Integration digital / IT services and improved technology and systems to support internal services and workforce.

Throughout the year the Committee has achieved perfect score in respect of the Better Payment Practice Code for both NHS and non-NHS payments.

The Chair of the Audit and Risk Committee attends this 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.

People Committee

Non Executive Members: Chair –Mr. Martin Evans, Ms. Valerie Little and Dr. George Solomon

Committee Self-Assessment Rating: Strong

Frequency of meeting: The Committee met ten (10) times during the year.

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.

During the year, the committee received and discussed reports on:

- Strategies including People, Communication, Equality, Diversity and Inclusion, Workforce Planning, Organisational Development and Education and Training Strategy
- Workforce Performance as against the Workforce Dashboard and KPI's
- Flu and Covid 19 vaccinations
- Staff Experience Report including National Staff Survey Report
- Health and Wellbeing Implementation Plan
- Organisational Development

The Equality, Diversity, and Inclusion (EDI) Committee reports into the People Committee key updates and develops EDI action plan for successful transfer of services and Human Resources. The Anti Racism statement was approved by the Board and the Trust brought the Freedom To Speak Up (FTSU) services in house having being supported by our partner from Black Country Healthcare NHS Foundation Trust.

The Chair of the Equality, Diversity and Inclusion Committee is a member of this Committee, which helps to maintain the flow of information between the committees, particularly on human risks. Non-Executive Directors' attendances were recorded as being high during the year, and the Committee was quorate at each meeting.

Appointment and Remuneration Committee

Members: Chair – Mr. Harry Turner all Non-Executive Directors (NEDs) and Associate Non-Executive Directors

The purpose of this committee is to advise the Trust Board about appropriate appointment, remuneration and terms of service for the Chief Executive and other Executive Directors. The Appointment and 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 their absence). The Chair completed all of the Non-Executive Director's appraisals and the Senior Independent Director (SID) completed the appraisal of the Chairs performance including multisource assessments.

Capacity to Handle Risk

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

Earlier in the report we outlined the governance committee structure, the key responsibilities of the committees as well as the following information:

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

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

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

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

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

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

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

Title	Role / Responsibility
Chief Executive	As Accountable Officer has overall responsibility for the Trust's risk management programme and for ensuring that this system operates effectively and that there is a sound system of place to manage risks within the organisation.
Trust Secretary	Retains the delegated responsibility for the development of the Trust's Board Assurance and Risk Management Strategy and ensures integration of key policies and procedures around risk management to the wider framework arrangements. It is also their role to prepare a Board Assurance and Risk Management Report for Board.
Medical Director	Responsible for maintaining effective governance arrangements which support the appropriate escalation and management of risks within the clinical divisions and service treams, including risks surrounding medication management, pharmacy, etc. The Medical Director also acts as the Trust's Caldicott Guardian. It is the role of the Caldicott Guardian to be responsible for the oversight of the arrangements in that organisation for the use and sharing of clinical information.
Director of Nursing, Allied Health Professionals and Quality	The designated Board member with overall responsibility for the the Trust's organisational risk management systems, the Trust's Clinical Governance arrangements and is responsible for ensuring that there are sufficient resources directed to ensuring they are appropraitely managed and mitigated.
Chief Operating Officer Operations	Responsible for ensuring the Trust's Health and Safety and operational risks held by the Trust's services and clinical teams are appropriatly managed and there are sufficient resources directed to ensuring these risks are appropraitely managed and mitigated.
Director of Strategy, People and Partnerships	Responsible for ensuring that inter-agency risks and risks associated with partnership working are shared with other organisations and the future strategic direction of the organisation are appropriately mitigated. In addiiton, holds the responsibility for ensuring risks within the People Directorate are appropriatly managed and there are sufficient resources directed to ensuring they are appropraitely managed and mitigated.

Title	Role / Responsibility
Director of Finance, Performance and Digital	Responsible for advising the Trust Board on all aspects of financial risks and ensuring that effective mechanisms are in place to manage this. The Director of Finance, Performance and Digital is also the Trust's Senior Information Risk Officer (SIRO). It is the role of the SIRO to take ownership of the organisation's information risk policy.
Associate Director of Governance, Quality and Risk	Retains the delegated responsibility for the development of the Trust's risk management policy and for the development of key policies and procedures for risk management utilising the Datix RL Risk Management system. They are also responsible for integrating these risk management systems with other clinical governance processes.
Governance / Risk Manager	Ensures the day to day running of the Trust's Risk Processes within the organisation and has the delegated responsibility to ensure that the Trust's approach to risk management is robust and complies with best practice and that risk management systems are maintained to manage risk effectively. It is also their role to prepare a number of 'risk reports' for appropriate committees to facilitate the Chair in the execution of their duties as defined within the Board Committee Terms of Reference.
Heads of Service / Divisional Management	It is the role of divisonal management to ensure that routine reviews of all divisional / service risks are completed, in collaboration with their respective Heads of Nursing / AHPs / Heads of Service. Ensuring that all divisional / Service high level risks are routinely reviewed and escalated according to the internal governance processes and risk management and assurance framework.
All Staff	Management of risk is a fundamental duty of all staff. All staff must ensure that identified risks and incidents are reported in order to ensure appropriate actions are taken. These requirements also extend to agency staff.
Partner Organisations and Contractors	Specific risks identified in the Trust will be shared with any other relevant organisation working in partnership with the Trust.

The Trust adopts a structured and pragmatic approach to risk management training with training on utilising RL Datix risk and incident management system available to all staff.

All board members and senior managers undergo specialist risk management training as a mandatory requirement.

The Risk and Control Framework

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

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

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.

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

As an organisation we understand that successful risk management requires participation, commitment, and collaboration from all staff. To support this the Board provides a clear overarching framework for the management of internal and external risk and describes the accountability arrangements, processes, and the Trust's risk appetite.

The Trust's approach to risk management encompasses the breadth of the organisation by considering financial, organisational, reputational and project risks, both clinical and non-clinical. This is achieved through:

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

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

Staff are encouraged to report any potential fraud using the online incident reporting process appropriately including anonymous reporting if necessary. We

are not aware of any specific areas within the organisation that are at risk of material fraud, however we cannot be complacent and continue to develop the proactive work in this area.

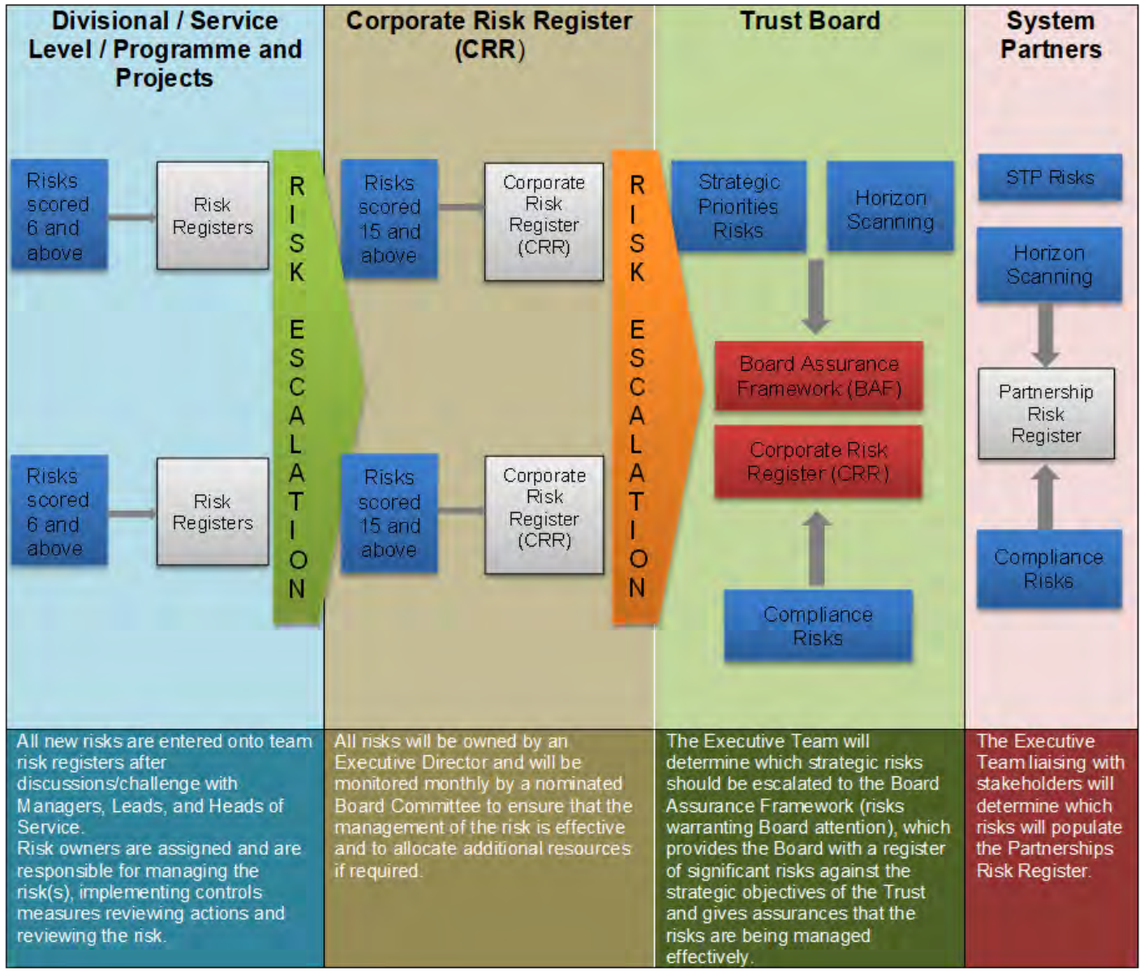
The Corporate Risk Register is supported by the implementation of Datix module of risk management, the incident module had been implemented from 1st April 2021 and is now fully embedded and has provided the ability for real time reporting and escalation; it also aligns existing systems used for incident,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

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

There is clear alignment between the Board Assurance Framework and the operational corporate risk register and our risk report summarises the key risks and provides analysis of the changes are reported through the committees each month. In practice this means:

- reviewing internal sources of intelligence and activity relating to risks in order to inform local and Trust level risk registers and assurance frameworks including incidents, complaints and audits
- using committee reports to inform on emerging risks and supported by committee and working group reviews
- formalising the escalation process with a standardised approach to reporting, scoring and escalation
- monitoring of controls through positive and negative assurances to mitigate and manage to tolerance for residual risks
- integrating risk with governance and performance systems to ensure strategic and operational risk are captured at all levels

Risks identified will be escalated in line with the framework outlined overleaf in the Risk Escalation Framework.



Our Key Risks and Issues

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

The key risks to our strategic plans were identified as:

- BAF 001 – Impact of the ICP contract not being awarded, or significantly delayed
- BAF 002 - Insufficient resources in place to safely and effectively manage and improve existing services
- BAF 003 - Insufficient resources and systems in place to safely and effectively manage the potential transfer of additional services
- BAF 004 – Governance arrangements not as connected, adaptable, agile, responsive or supportive of the innovation and transformation
- BAF 005 – The Trust is unable to meet demand in relation to the COVID-19 response
- BAF 006 – The Trust is unable to effectively engage with its system partners and demonstrate appropriate system leadership
- BAF 007 – Financial sustainability will be impacted by future changes to the NHS financial regime
- BAF 008 – The Trust cannot recruit, train and retain the appropriate innovative workforce

We accept that risks which fall outside of the remit of routine clinical assessment or are potentially significant for the organisation are approached and managed in line with the BAF and Risk Management Strategy.

Management of the risk registers within the Trust

Risk registers are managed at the following levels:

- Directorate/Service– operational risks that include clinical, business/service, financial, reputational, and service users/staff/stakeholders
- Corporate Risk Register (CRR) – Any risks graded as 16 or above or have significant reputational risk are escalated to the CRR for consideration by the Board of Directors. This has the purpose to inform the Trust Board of operational risks which may adversely impact the BAF and strategic objectives. Risks and 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.

The Board and Committees discuss the key risks at each meeting support by risk-based agendas that are embedded throughout the Trust from Board, committees, steering groups to divisional operational meetings. This has ensured every manager remains responsible for the oversight of quality and risks, triangulating performance information to monitor and address service quality at all levels. These divisional meetings provide exception reporting to the Quality and Safety Steering Group which is chaired by the Medical Director, and these are then scrutinised at the Quality and Safety Committee. The service line structure provides high levels of autonomy increasing the effectiveness and accountability of the services.

- Oversight of performance and risk by the Executive Team via daily escalation and reporting through to the weekly Executive Committee.
- Contract, Quality & Risk Management Meeting (CQRM) the monthly monitoring with commissioners.
- Visits by the Board and senior leadership team engaging with staff and service users.
- Learning from serious incident reviews.
- Audit programme and self-assessments, trust wide and service level covering standards and topic specific issues.
- Our Quality Account which outlines the progress made and action taken to improve and maintain quality and safety within and across Trust services.

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

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.

Annual Declarations

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

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

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

Dudley Integrated Health and Care NHS Trust is required to register with the CQC, and its current registration status is active. DIHC has no conditions with its continued registration.

The CQC has not taken enforcement action against Dudley Integrated Health and Care NHS Trust during 2021/22.

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

In compliance with the Health and Social Care Act 2008, the Trust has an effective system in place to assess all Directors have annually signed up to the Code of Conduct and Fit and Proper Persons Policies setting out the requirement for all Board members to declare any interests that may compromise their role. The Trust Secretary maintains the following records on behalf of the Chair:

- Annual self-declaration on fitness to practice, signed by every director
- Annual declaration of Interest, signed by every director
- Confirmation of professional qualifications and registration (where relevant to the post; Medical and Financial qualifications)

We have published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (https://www.dihc.nhs.uk/publications/board-papers/50-dudley-ihc-board-declaration-of-interest-register) 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.

The Trust has not made any Political Donations for the year 2021/22.

Equality, Diversity, and Inclusion

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Reported in the Performance Analysis section under the heading Workforce Performance Summary.

Freedom to Speak Up

DIHC has worked hard to progress Freedom to Speak Up these last 12 months and continues its journey towards creating a culture of speaking up within a safe environment and ensuring that speaking up is business as usual. DIHC has been committed to its journey and during the Summer of 2021 the Guardian role has been supported by our own internal FTSU Guardian. The Trust Board have shown their full commitment and support to embed FTSU within the organisation supporting national policy and requirements.

The Trust has been working with the FTSU Guardian to progress the below 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 FTSU objectives are:

- Develop Strategy and refresh policy for approval at public board in October 2022.
- Annual declaration and Board Statement on the principles of FTSU.
- Develop the DIHC's relationship with the National Guardian
- Include FTSU in NED and Executive Director appraisals.
- FTSU included in the Board Development programme.
- Implement the National Guardian Training resources as mandatory for all staff, managers, and Senior Managers.
- Provision of a dedicated Guardian one day per week to raise awareness by visiting services, hosting sessions and workshops. It should be noted that the Service Level Agreement with Black Country Healthcare NHS Foundation Trust for speaking up ended on 31 March 2022.
- Development of an assurance map, identification of risks and inclusion following due diligence from transferring in services.
- Development of quarterly board reports on progress towards the delivery of FTSU Action Plan to People Committee and to Public Board and on embedding the FTSU programme supported clear activities to develop the right culture.
- Engagement of Internal Audit Assurance as part of the wider assurance and internal control audits.

The Freedom to Speak Up Guardian has had a successful year, below are an outline of some of the achievements:

- Appointment of the first DIHC Freedom to Speak Up Guardian (Mwamba Bupe Bennett) during Quarter 3 of 2021
- Developing relationship with local, regional, and national FTSU Guardian Networks.
- Continued engagement with new and existing DIHC staff.

National FTSU Index

The National Guardian Office publishes a FTSU Index, to monitor 'speaking up culture' in the NHS. NHS England

commissioned the National's Guardian Office to develop the index based on questions from the annual NHS Staff Survey including whether staff feel secure raising concerns if they see something unsafe.

The 2021 FTSU Index was published in May 2021, however as this is based on the 2020 NHS Staff Survey DIHC is not included. The results from the 2022 FTSU Index will be reviewed as soon as they are available.

FTSU Recording and Monitoring of Cases

A total number of 3 cases were brought to the FTSU Guardian. The outcomes agreed with the DIHC staff raising the concern were as follows:

- 1 decided to raise it directly with the DIHC People Team.
- 1 case was raised via the DIHC anonymous feedback route.
- 1 case was raised with the line manager and resolved.

The DIHC FTSU Guardian followed up and confirmed that the staff member, in each of these cases, did not require any further support regarding the above cases but would notify the FTSU Guardian if this changed in the future.

Below is the total number of cases received. The FTSU Guardian will be focusing efforts in the 2022/23 financial year to re-launch the FTSU Service and will work closely with the communications team on this aspect.

2021/22	Total number of cases brought to Freedom to Speak Up Guardian	Cases raised anonymously	Number of cases with an element of patient safety/quality	Number of cases related to behaviours, including bullying / harassment	Number of cases where people indicate that they are suffering detriment as a result of speaking
Q1 (April to June 2021)	0	0	0	0	0
Q2 (July to September 2021)	0	0	0	0	0
Q3 (October to December 2021)	3	1	0	3	0
Q4 (January to March 2022)	0	0	0	0	0

All three cases reported were in quarter 3 where the DIHC Guardian was appointed and started to engage with staff. During 2022-23 the FTSU Guardian will continue to engage with staff raise awareness of and encourage to speaking up.

National Data is collected by the National Guardian Office; however, the National Guardian Office have requested for data not to be used for benchmarking purposes. Comparison to other NHS Providers is also made more difficult due to the size of DIHC.

The FTSU West-Midlands Regional Networks have been beneficial in sharing and comparing FTSU Guardian roles, sharing good practice and joint working across the networks. DIHC have benefited from support from our partners at Black Country Healthcare NHS Foundation Trust and their Guardians, Michael Hirons and Roger Bishton.

The Black Country and West Birmingham ICS has also established a FTSU Guardian network to provide additional support and an opportunity for further collaboration.

Greener NHS Programme

The Trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

We have published our three-year Green Plan in February 2022.

Internal Audit on Sustainability – Pathway to Delivering Net Zero

A moderate rating was given, and four actions identified. Two of the four actions have been implemented, approval of the Green Plan and publication on the website. The remaining action of inclusion of Greener NHS principles within terms of reference and communication and staff engagement is under development.

Review of Economy, Efficiency, and Effectiveness of the use of Resources

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

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

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

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

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

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

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

A financial plan was approved and monitored by the Board.

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

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

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

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

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

DIHC have had no Information Commissioners Office (ICO) reportable incidents within 2021/22 Information Governance Incidents are monitored and reviewed by the Trusts Information Governance Group which reports any high-risk incidents to Finance and Performance Committee.

Data Security and Protection Toolkit

The Data Security and Protection Toolkit (DSPT) is based upon the National Data Guardian Standards. The toolkit for 2021/22 is broadly like that issued in 2020/21, structured around the ten data security standards which remain unchanged.

The deadline for the submission of the Toolkit has been extended to 30th June 2022 due to Covid (originally 31st March 2022). The Trust utilises an outsourced IT services provider, TeraFirma (hosted by Dudley Group NHS Hospitals Foundation Trust) who are required to provide evidence to the Trust to support compliance with the toolkit for each annual submission. Based on the Trust's baseline toolkit submitted March 2022 it met compliance with thirteen (13) mandatory assertions.

Relevant Data Security training is mandatory for all staff within the Trust in accordance with national information governance standards and the Trust is reporting to have met the 95% mandated standards. The Trust ensures that all new starters complete their mandatory training within Information Governance and Data Security and all staff have completed the training within the past 2 years. The Trust has regular IG communications sent to all staff and there are full actions plans in place to increase the training compliance across the Trust. Any incidents and/or risks associated with data and information security are reported and dealt with in accordance with the Trust risk management and incident reporting policies.

Over the course of this year, the Trust has continued to improve and closely monitor progress with the Data Security and Protection Toolkit and is currently on target to submit a full 2021/22 return by the submission deadline of end of June 2022 to evidence all required standards being met.

Internal Compliance Review on Data Security and Protection Toolkit (DSPT)

A moderate assurance rating had been given following the internal audit against the evidence requirements set out by NHS Digital during 2020/21 and a compliance review conducted for 13 of the assertions across the ten National Data Guardians Standards in the DSPT. Overall, a moderate assurance rating was given, and the Trust will ensure implementation of the recommendations to strengthen the assurances and processes that support the assertions in order to achieve a compliant DSPT.

Cyber Security

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

Data Quality and Governance

In relation to data quality and management, the Trust:

- Completes data flow mapping and has developed charts and risk assessments in relation to the data flows across the organisation as well as externally. Data flow mapping charts have been created in line with developments within the Trust in 2021-22.
- Has agreements in place for data quality with both the CCG and BCHFT, and gains assurances directly from each organisation.

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

Performance information relating to our mental health services is provided through a service level agreement with Black Country Healthcare NHS Foundation Trust (BCHFT). This information is subject to BCHFT data quality processes. For assurance purposes, DIHC included an IAPT data quality audit as part of the internal audit plan for 2021/22. The audit provided moderate assurance and subsequently a number of actions have been agreed to improve data quality in 2022/23 as part of the development of an in-house Business Intelligence function.

Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

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

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

Head of Internal Audit Opinion

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

During the year, all reviews received significant or full assurance with the exception of Health & Safety arrangements, Sustainability: Pathway to net zero and the Data Security & Protection Toolkit 2020/21 submission which received moderate assurance.

During the year internal auditors provided a range of individual opinions arising from the risk-based audit assignments that have been reported throughout the year.

The internal audit plan for 2021/22 was developed to provide independent assurance on the adequacy and effectiveness of systems of control across a range of financial and organisational areas. To achieve this the internal audit plan was divided into two broad categories; work on the financial systems that underpin financial processing and reporting and then broader risk focused work driven essentially by principal risk areas that had identified in through the Trust Board Assurance Framework.

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

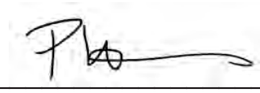
The HOIA also highlights areas of good practice including development of an effective Board Assurance Framework, recognising the development of the Trust, and achieving significant assurance across the reviews and implementing all audit actions effectively.

Full Assurance	• Financial governance
Significant Assurance	• Financial systems • Continuing healthcare • Quality Framework • Partnership working with PCNs • Dudley School Health Services
Moderate Assurance	• Health and safety arrangements • Sustainability pathway towards delivering net zero
Limited Assurance	• None
No Assurance	• None
Other	• DSP Toolkit submission 2020/21 • Assurance Framework Checklist - Level A

Conclusion

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

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

Signed 

Penny Harris - Chief Executive Officer
Date: 22nd June 2022

Remuneration and Staff Report

This Remuneration and Staff Report is part of the Accountability Report.

It comprises a Remuneration Report and a Staff Report. The elements which are subject to audit are clearly noted.

Remuneration Report

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

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

Remuneration Policy

Our Chair is appraised on an annual basis by NHSEI.

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

The other directors are appraised by the Chief Executive. The Appointment and Remuneration Committee have not determined any performance related pay arrangements or bonuses for employed staff. Recommendations were made in relation to staff on secondment from the CCG.

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

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

Directors' Remuneration and Terms and Conditions

Senior Managers Remuneration

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

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

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

All Directors receive regular appraisals.

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

- Chief Executive
- Joint Medical Directors

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

- Director of Finance, Performance and Digital
- Director of Nursing and Allied Health Professionals and Quality (up to 31/07/2021 only)
- Director of Operations, Strategy and Partnerships (up to 1st October 2021 following which substantive appointment was made to Director of Strategy, People and Partnerships)

No termination payments have been made during the reporting period.

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

Remuneration Report Tables (Subject to Audit)
Single Total Figure Table – 2021/22

Name	Title	Period	(a) Salary (bands of £5,000)	(b) Expense payments (taxable)to the nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to d) (bands of £5,000)
			£000	£	£000	£000	£000	£000
Harry Turner	Chair	01/04/21 to 31/03/2022	45-50	-	-	-	-	45-50
Paul Assinder	Chief Executive	01/04/2021 to 31/12/2021	70 -75	-	-	-	-	70-75
Penny Harris	Chief Executive	01/01/2022 to 31/03/2022	35-40	-	-	-	-	35-40
Caroline Brunt	Director of Nursing and Allied Health Professionals	01/04/2021 to 31/08/2021	45-50	1,400	5-10	-	12.5-15.0	65-70
Sue Nicholls	Director of Nursing, Allied Health Professionals and Quality	05/10/2021 to 31/03/2022	90-95	-	-	-	62.5-65.0	155-160
Matthew Gamage	Director of Finance, Performance and Digital	01/04/21 to 31/03/2022	105-110	-	0-5	-	40.0-42.5	150-155
Stephanie Cartwright	Director of Strategy, People and Partnerships and Deputy Chief Executive	01/04/21 to 31/03/2022	125-130	-	5-10	-	90.0-92.5	225-230
Phillip King	Chief Operating Officer	05/10/2021 to 31/03/2022	50-55	-	-	-	-	50-55
Dr Lucy Martin	Joint Medical Director	01/04/21 to 31/03/2022	60-65	-	-	-	15.5-17.5	75-80
Dr Richard Bramble	Joint Medical Director	01/04/21 to 31/03/2022	60-65	-	-	-	67.5-70.0	130-135
Ian Buckley	Deputy Chair and Senior Independent Director	01/04/21 to 31/03/2022	10-15	-	-	-	-	10-15
Martin Evans	Non-Executive Director	01/04/21 to 31/03/2022	10-15	-	-	-	-	10-15

Continued - Remuneration Report Tables (Subject to Audit)
Single Total Figure Table – 2021/22

Name	Title	Period	(a) Salary (bands of £5,000)	(b) Expense payments (taxable)to the nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to d) (bands of £5,000)
			£000	£	£000	£000	£000	£000
David Gilburt	Non-Executive Director	01/04/21 to 31/03/2022	10-15	-	-	-	-	10-15
Valerie Little	Non-Executive Director	01/04/21 to 31/03/2022	10-15	-	-	-	-	10-15
Dr George Solomon	Non-Executive Director	01/04/21 to 31/03/2022	10-15	-	-	-	-	10-15
Stephen Cartwright	Associate Non-Exec Director	01/04/21 to 31/03/2022	10-15	-	-	-	-	10-15
Billie Lam	Associate Non-Exec Director	01/07/21 to 31/03/2022	5-10	-	-	-	-	5-10
Gillian Love	Associate Non-Exec Director	01/04/21 to 31/03/2022	10-15	-	-	-	-	10-15

Note
Senior managers bonuses disclosed above were not determined by DIHC as all the recipients were seconded into DIHC from the CCG.

Remuneration Report Tables
Single Total Figure Table – 2020/21

Name	Title	Period	(a) Salary (bands of £5,000)	(b) Expense payments (taxable)to the nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to d) (bands of £5,000)
			£000	£	£000	£000	£000	£000
Harry Turner	Chair	2020 - 2021	45-50	500	-	-	-	45-50
Paul Assinder	Chief Executive	2020 - 2021	85-90	-	-	-	-	85-90
Caroline Brunt	Director of Nursing and Allied Health Professionals (Interim)	2020 - 2021	110-115	3500	5-10	-	62.5-65	185-190
Matthew Gamage	Director of Finance, (Interim)	2020 - 2021	105-110	-	5-10	-	132.5-135	245-250
Stephanie Cartwright	Director of Strategy, People and Partnerships and Deputy Chief Executive	2020 - 2021	110-115	-	0-5	-	127.5-130	245-250
Dr Chris Weiner	Interim Medical Director	2020 - 2021	130-135	-	-	-	77.5-80	205-210
David Gilburt	Non-Executive Director	2020 - 2021	10-15	-	-	-	-	10-15
Ian Buckley	Deputy Chair and Senior Independent Director	2020 - 2021	10-15	-	-	-	-	10-15
Martin Evans	Non-Executive Director	2020 - 2021	10-15	-	-	-	-	10-15
Valerie Little	Non-Executive Director	2020 - 2021	10-15	-	-	-	-	10-15
Dr George Solomon	Non-Executive Director	2020 - 2021	10-15	-	-	-	-	10-15

Medical Directors total remuneration and pension benefits in relation to clinical role was as follows: Dr Chris Weiner £145,000 - £150,000

Between 1 May 2020 and 31 March 2021, the services of Dr Chris Weiner as Interim Medical Director were provided under an agreement with NHS England and Improvement. The benefit paid to NHS England 1 April 2020 and 31 March 2021 in respect of these services was £147,000. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

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

Pension benefits 2021-22 (Subject to Audit)

Name	Title	Notes	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2021	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2022	(h) Employer's contribution to stakeholder pension
			£000	£000	£000	£000	£000	£000	£000	£000
Dr Richard Bramble	Joint Medical Director		2.5-5.0	5.0-7.5	5 - 10	20-25	94	52	157	-
Caroline Brunt	Director of Nursing and Allied Health Professionals	1	0-2.5	0-2.5	40-45	105-110	876	-	-	-
Stephanie Cartwright	Director of Strategy, People and Partnerships and Deputy Chief Executive		5.0-7.5	7.5-10.0	35-40	70-75	480	68	568	-
Matthew Gamage	Director of Finance, Performance and Digital		2.5-5.0	0-2.5	35-40	75-80	497	29	543	-
Dr Lucy Martin	Joint Medical Director		0-2.5	0-2.5	15-20	45-50	317	14	342	-
Sue Nicholls	Director of Nursing, Allied Health Professionals and Quality	2	2.5-5.0	7.5-10	30-35	55-60	365	50	497	-

Notes

1. 1st April 2021 to 31st August 2021

2. 5th October 2021 to 31st March 2022

The following directors chose not to be covered by the pension arrangements during the reporting year.

- *Penny Harris*
- *Paul Assinder*
- *Philip King*

Pension benefits 2020-21 (Subject to Audit)

Name *Period of Office* *(if not 01/04/2020 – 31/03/2021)*	**Title**	**(a)** **Real increase in pension at pension age (bands of £2,500)**	**(b)** **Real increase in pension lump sum at pension age (bands of £2,500)**	**(c)** **Total accrued pension at pension age at 31 March 2022 (bands of £5,000)**	**(d)** **Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)**	**(e)** **Cash Equivalent Transfer Value at 1 April 2021**	**(f)** **Real increase in Cash Equivalent Transfer Value**	**(g)** **Cash Equivalent Transfer Value at 31 March 2022**	**(h)** **Employer's contribution to stakeholder pension**
		£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Caroline Brunt	Director of Nursing and Allied Health Professionals (Interim)	2.5-5.0	2.5-5.0	35-40	105-110	777	71	876	-
Matthew Gamage	Director of Finance	5.0-7.5	12.5-15.0	30-35	70-75	385	91	497	-
Stephanie Cartwright	Director of Operations, Strategy and Partnerships	5.0-7.5	12.5-15.0	30-35	60-65	366	93	480	-
Dr Chris Weiner	Interim Medical Director	2.5-5.0	5.0-7.5	30-35	65-70	483	62	570	-

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

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

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

Cash Equivalent Transfer Values

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

The benefits and related CETVs do not allow for a potential future adjustment for some eligible employees arising from the McCloud judgement.

Real Increase in CETV

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

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

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

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

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

Treatment of Pension Liabilities in the Accounts

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

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

Compensation for loss of office (Subject to Audit)

The Trust made no compensation for loss of office during 2021/22.

Payments to Past Directors (Subject to Audit)

The Trust made no payments to past directors during 2021/22.

Fair Pay Disclosure (Subject to Audit)

Pay Ratios

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of total remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director in DHIC in the financial year 2021-22 was £142,500 (2020-21, £132,500). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

The ratio for the current year has increased because of the increase of the highest paid director

In the current year and previous year there were no employees who received remuneration more than the highest paid director.

Remuneration ranged from £2,229 to £140,800 (£5650 to £131,031 2020/21)

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

Pay Ratio Table			
2021-22	**25th percentile**	**Median**	**75th percentile**
Total remuneration	19,918	27,742	40,057
Salary component of total remuneration	19,909	27,727	40,057
Pay ratio information	**7.2**	**5.1**	**3.6**
2020-21			
Total remuneration	19,337	26,532	38,890
Salary component of total remuneration	19,261	25,342	38,890
Pay ratio information	**6.9**	**5.2**	**3.4**

Percentage Change in Remuneration of Highest Paid Director

The percentage changes in remuneration of highest paid director compared to the previous year are as follows.

- the percentage change from the previous financial year in respect of the highest paid director - salary and allowances was 7.55%
- the percentage change from the previous financial year in respect of the highest paid director - performance pay and bonuses was -nil
- the average percentage change from the previous financial year in respect of employees of the entity, taken as a whole - salary and allowances was 7.98%
- the average percentage change from the previous financial year in respect of

employees of the entity, taken as a whole - performance pay and bonuses was -52.97%. This is mainly because the FTE has increased current year from 181 to 296 and in addition to that there was a reduction of performance bonus paid to one director.

Staff Report

Our workforce is typical of most NHS provider organisations with female staff making up most employees, in our case 82.8% (2020/21 – 79.9) of our workforce.

Number of senior civil service staff (or senior managers) by band	
Pay Banding	**Headcount**
Band 8 – Range A	6
Band 8 – Range B	8
Band 8 – Range C	7
Band 8 – Range D	1
VSM / Medical	9
Total	31

Staff Numbers and Costs (Subject to Audit)

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

Excluding NEDs		2021/22 Staff Numbers WTE	
Average number of Staff in Post (1 April 2021 - 31 March 2022) Staff Group	**Permanent**	**Other ***	**Total Number**
Additional Prof Scientific and Technical	59	2	61
Additional Clinical Services	39	11	50
Administrative and Clerical	52	15	67
Allied Health Professionals	14	0.00	14
Medical and Dental	2	2	4
Nursing and Midwifery Registered	51	2	53
TOTAL	**217**	**32**	**249**

** (Fixed Term, Locum, Inward Secondments & Bank Staff)*

The year-end Whole Time Equivalent (WTE) number of staff is 289 (headcount of 354). The average number of employees in the table above is lower than this, reflecting the significant growth in staffing numbers during the year.

2020/21 staff costs and numbers within this report show the lower number of staff which were employed which is a reflection of additional services (such as School Nursing, PCN additional staff and Pharmacy services from the CCG) taken over by DIHC during the current year. See table below showing 2020/21 staff average numbers.

Average Staff Numbers	2020/21		
	Permanent No	Other No	Total No
Medical and dental	2	0	2
Administration and estates	29	10	39
Healthcare assistants and other support staff	13	4	17
Nursing, midwifery and health visiting staff	24	0	24
Scientific, therapeutic and technical staff	25	1	26
Other	2	0	2
Total average numbers	**95**	**15**	**110**

The year end Whole Time Equivalent number of staff in 2020/21 was 181 (headcount of 221). Similarly, to the current year, the average number of employees in the table above is lower than the year end figure, reflecting the growth in staffing numbers during the year.

Staff Costs	2021/22			2020/21
	Permanent £000	Other £000	Total £000	Total £000
Salaries and wages	10,443	812	10,961	4,936
Social security costs	1,011	-	1,011	402
Apprenticeship levy	36	-	36	5
Employer's contributions to NHS pensions	1,745	23	1,768	763
Pension cost – other	-	-	-	-
-Termination benefits	-	-	-	-
Temporary staff	**-**	**2,342**	**2,342**	**1,413**
Total gross staff costs	**13,235**	**2,883**	**16,118**	**7,519**
Of which:				
Costs capitalised as part of assets	**-**	**-**	**-**	**-**

Staff Composition

Staff Composition by Gender			
Title	**Female**	**Male**	**Total**
Executive Directors	5	2	7
Senior Managers	13	11	24
Other Employees	275	48	323
TOTAL	**292**	**61**	**354**

Staff Composition by Grade			
Grade	**Female Headcount No**	**Male Headcount No**	**Total Headcount No**
Director	5	2	7
Employee	288	59	347
TOTAL	**293**	**61**	**354**

Staff Turnover

Staff turnover for the Trust is as reported in the NHS Workforce statistics which can be found here NHS workforce statistics - NHS Digital

Staff Survey

63% of staff who were involved in the national staff survey would recommend DIHC as a place to work or receive treatment.

Sickness Absence Data

The rolling 12-month sickness absence (FTE) percentage for 21/22 was 3.15%, which remained below the Trust target of 4.68%. Breakdown the sickness absence figures for each month throughout the financial year can be found from the below table and also via NHS digital publication services on 'NHS Sickness Absence Rates' NHS Sickness Absence Rates - NHS Digital

Month	Sickness Absence (FTE) %
Apr-21	0.83%
May-21	1.79%
Jun-21	1.95%
Jul-21	3.29%
Aug-21	3.41%
Sep-21	2.29%
Oct-21	3.68%
Nov-21	2.38%
Dec-21	3.57%
Jan-22	4.60%
Feb-22	2.68%
Mar-22	2.71%

Staff Policies

During 2021/22 DIHC have undertaken a detailed piece of work to review and revise the previous Dudley and Walsall Mental Health Trust policies which were adopted as part of the legacy arrangements. Policies are located on our intranet site for all staff. We have begun a process of harmonisation of policies to ensure they are aligned to our organisational commitments and objectives.

Supporting Staff with Disabilities

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

Trade Union Facility Time Reporting Requirements

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

Percentage of Time Spent on Facility Time

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

Percentage of Time	Number of Employees
0%	1
1-50%	1
51%-99%	-
100%	-

Percentage of Pay Spent on Facility Time

First Column	Figures
Provide the total cost of facility time	£1,393
Provide the total pay bill	£16,118
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.009%

Paid Trade Union Activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	2.308%

Expenditure on Consultancy

Expenditure on consultancy in 2021/22 was £639,000 (2020/21: £595,000).

Reporting Related to the Review of Tax Arrangement of Public Sector Appointee

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

Off-Payroll Engagements

For all off-payroll engagements as of 31 March 2022, for more than £245 per day and that last for longer than six months. There were no such engagements in 2021/22.

	Number of off-payroll engagements No.
No. of existing engagements as of 31 March 2022	0
Of which:	
No. that have existed for less than one year at time of reporting	0
No. that have existed between one and two years at time of reporting	0
No. that have existed between two and three years at time of reporting	0
No. that have existed between three and four years at time of reporting	0
No. that have existed between four years or more at time of reporting	0

New Off-Payroll Engagements

For all new off-payroll engagements, or those that have reached six months in duration, between 1 April 2021 and 31 March 2022, for more than £245 per day and that last for longer than six months. There are no such engagements in 2021/22.

	Number of off-payroll engagements No.
No. of new engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022	0
Of which:	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to the entity) and are on the departmental payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Off-Payroll Board Members/Senior Official Engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022.

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

Reporting of Compensation Schemes – Exit Packages 2021/22

Exit Packages (Subject to Audit)

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

Reporting of Compensation Schemes – Exit Packages 2021/22

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

Exit Packages: Other (Non-Compulsory) Departure Payments

	2021/22		2020/21	
	Number of payments agreed	Total value of agreements £000	Number of Payments agreed	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignation (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	-	-	-	-
Of which:	-	-	-	-
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Independent Auditor's Statement to the Board of Directors of Dudley Integrated Health and Care NHS Trust on the NHS Trust Consolidation Schedules

We have examined the consolidation schedules of Dudley Integrated Health and Care NHS Trust, version 1.21.12.2A for the year ended 31 March 2022, which have been prepared by the Director of Finance and acknowledged by the Chief Executive. Our examination of the consolidation schedules covers the following:

- Designated TAC02 to TAC29 for tables outlined in red, excluding TAC05A and TAC23.

For the purpose of this statement, reviewing the consistency of figures between the audited financial statements and the consolidation schedules extends only to those figures within the consolidation schedules which are also included in the audited financial statements.

Auditors are required to report on any differences over £300,000 between the audited financial statements and the consolidation schedules, with the following exception (which also applied in 2020/21), as set out in NHS England's accounting guidance and the National Audit Office Consolidated NHS Provider Accounts Group Reporting Suppporting Information and FAQs :

- PPE inventory – where trusts do not recognise consumables in inventory on the grounds of materiality, and inventory remains immaterial, the receipt and utilisation may be omitted from the inventory note in local accounts. However, trusts should record the receipt of items in inventory with an equivalent figure in utilisation within the TAC form. (see page 8 of Guidance-for-20-21-accounts-issue-v3.pdf (england.nhs.uk).

Unqualified audit opinion on the audited financial statements; no differences identified:

The figures reported in the consolidation schedules are consistent with the audited financial statements, on which we have issued an unqualified opinion.

Use of our statement

This statement is made solely to the Board of Directors of Dudley Integrated Health and Care NHS Trust in accordance with Part 5 paragraph 20(5) of the Local Audit and Accountability Act 2014 and paragraph 4.8 of the Code of Audit Practice 2020 and for no other purpose. Our work has been undertaken so that we might state to the Board of Directors those matters we are required to state to them in a consistency statement and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Board of Directors as a body, for our audit work, for this statement, or for the opinions we have formed.

Grant Thornton UK LLP

Grant Thornton UK LLP

Birmingham

29 June 2022

Independent Auditor's Report to the Directors of Dudley Integrated Health and Care NHS Trust

In our auditor's report issued on 22 June 2022, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2022, in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice, until we had:

- Completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2022 issued on 22 June 2022 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

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

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

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

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

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

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

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of Dudley Integrated Health and Care NHS Trust for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

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

Laurelin Griffiths

Laurelin Griffiths, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor
Birmingham
20 September 2022

NHS
Dudley Integrated Health and Care
NHS Trust

Annual Accounts for the Year Ended 31 March 2022

Statement of Comprehensive Income

	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	3	19,390	8,153
Other operating income	4	2,063	2,735
Operating expenses	6, 7	(20,849)	(10,738)
Operating surplus/(deficit) from continuing operations		**604**	**150**
Finance income	10	2	-
Finance expenses	11	(69)	(109)
PDC dividends payable		-	(3)
Net finance costs		**(67)**	**(112)**
(Losses) arising from transfers by absorption	24	-	(45,500)
Surplus / (deficit) for the year		**537**	**(45,462)**
Total comprehensive income / (expense) for the period		**537**	**(45,462)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		537	(45,462)
Remove losses on transfers by absorption		-	45,500
Adjusted financial performance surplus		**537**	**38**

Statement of Financial Position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Property, plant and equipment	13	503	39
Receivables	15	14	-
Total non-current assets		**517**	**39**
Current assets			
Receivables	15	1,516	1,859
Cash and cash equivalents	16	4,186	4,097
Total current assets		**5,702**	**5,956**
Current liabilities			
Trade and other payables	17	(3,371)	(2,960)
Borrowings	19	(1,133)	(1,133)
Provisions	20	(53)	-
Other liabilities	18	(180)	(85)
Total current liabilities		**(4,737)**	**(4,178)**
Total assets less current liabilities		**1,482**	**1,817**
Non-current liabilities			
Borrowings	19	(567)	(1,700)
Provisions	20	(41)	(27)
Total non-current liabilities		**(608)**	**(1,727)**
Total assets employed		**874**	**90**
Financed by			
Public dividend capital		2,568	2,321
Income and expenditure reserve		(1,694)	(2,231)
Total taxpayers' equity		**874**	**90**

The notes on the following pages form part of these accounts

Penny Harris
Chief Executive Officer
Date 22 June 2022

Statement of Changes in Equity for the year ended 31 March 2022

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**2,321**	**-**	**(2,231)**	**90**
Surplus for the year	-	-	537	**537**
Public dividend capital received	247	-	-	**247**
Taxpayers' and others' equity at 31 March 2022	**2,568**	**-**	**(1,694)**	**874**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**47,821**	**255**	**(2,524)**	**45,552**
(deficit) for the year	-	-	(45,462)	**(45,462)**
Transfers by absorption: transfers between reserves	(45,500)	(255)	45,755	**-**
Taxpayers' and others' equity at 31 March 2021	**2,321**	**-**	**(2,231)**	**90**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

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

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus		604	150
Non-cash income and expense:			
Depreciation and amortisation	6.1	21	13
decrease in receivables and other assets		329	3,795
Increase / (decrease) in payables and other liabilities		459	(2,387)
Increase / (decrease) in provisions		67	(1,094)
Net cash flows from operating activities		**1,480**	**477**
Cash flows from investing activities			
Interest received		2	9
Purchase of intangible assets		-	(85)
Purchase of PPE and investment property		(438)	(467)
Net cash flows (used in) investing activities		**(436)**	**(543)**
Cash flows from financing activities			
Public dividend capital received		247	-
Movement on other loans		(1,133)	2,833
Interest on loans		(69)	(109)
PDC dividend (paid)		-	(3)
Net cash flows from / (used in) financing activities		**(955)**	**2,721**
Increase in cash and cash equivalents		**89**	**2,655**
Cash and cash equivalents at 1 April - brought forward		**4,097**	**14,574**
Cash and cash equivalents transferred under absorption accounting	24	-	(13,132)
Cash and cash equivalents at 31 March	16.1	**4,186**	**4,097**

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 2021/22 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.

Our current size and small turnover does however warrant specific consideration of our sustainability.

Our first accounts reported a small operating surplus and we are, at the time of this report, planning a balanced budget for 2022/23. This is a major achievement within the current economic climate, with significant inflationary pressures affecting the NHS.

We are confident in our future growth as part of the Dudley Health and Care system, which will enable us to reach a more stable and sustainable size and income base. Dudley Integrated Health and Care NHS Trust, The Dudley Group NHS Foundation Trust and Black Country Healthcare NHS Foundation Trust are working together in the local system with Black Country and West Birmingham CCG to further integrate healthcare services for all in Dudley.

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.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at an Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. 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 also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

As per paragraph 121 of the Standard the Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less. The GAM does not require the Trust to disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

Note 1.4 Other forms of income

Apprenticeship service income

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

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

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

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have an individual cost of at least £250 and a collective cost of at least £5,000, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, 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 (ie 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.

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

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

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
Plant & machinery	-	10
Information technology	-	5
Furniture & fittings	-	10

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

Note 1.8 Intangible assets

Recognition

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

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg 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, eg application software, is capitalised as an intangible asset.

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Amortisation

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

Note 1.9 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 1.10 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, ie, 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 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.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

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

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

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

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

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

Note 1.11 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

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.

Note 1.12 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2022:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
Very long-term	Exceeding 40 years	0.66%	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 from 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 20.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.13 Contingencies

Contingent liabilities are not recognised, but are disclosed in note 21, 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 1.14 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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

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

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

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

Note 1.15 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 1.16 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 1.17 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 1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.21 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 without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust’s incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

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

The 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	28
Additional lease obligations recognised for existing operating leases	(28)
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(14)
Additional finance costs on lease liabilities	(0)
Lease rentals no longer charged to operating expenditure	14
Estimated impact on surplus / deficit in 2022/23	**(0)**
Estimated increase in capital additions for new leases commencing in 2022/23.	**8,413**

Note 2 Operating Segments

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

As a single segment the Trust receives £15,212,000 (2020/21: £8,281,000) of its income from CCGs. This equates to 71% (2020/21: 76%) of the Trust's total income of £21,453,000 (2020/21: £10,888,000).

The Trust receives in excess of 10% of its income from a single organisation, Black Country and West Birmingham CCG £15,212,000. In 2020/21 the Trust received in excess of 10% of its income from Dudley CCG £6,176,000. Dudley CCG has since merged with 3 other CCGs to form Black Country and West Birmingham CCG.

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)	2021/22 £000	2020/21 £000
Mental health services		
Block contract / system envelope income	3,546	3,437
Other clinical income from mandatory services	359	194
Community services		
Income from other sources (e.g. local authorities)***	1,457	-
All services		
Additional pension contribution central funding*	523	207
Other clinical income**	13,505	4,315
Total income from activities	**19,390**	**8,153**

*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.

** Other Clinical Income has increased by £9.2m in the financial year 21/22, as a result of the transfer of a services into the orgainsation, the full year-effect of transfers which took place in the 20/21 financial year and wider growth in services. The key areas of Other Clinical Income are:
- Services Provided to Primary Care Networks - £3.5m
- GP services provided at High Oak Surgery - £1.0m
- Clinical Services provided to Black Country & West Birmingham CCG not included within other categories - £8.9m
- Other - £0.1m

***Income relates to a contract for School Nursing Services awarded to the trust with a start date of 1st April 2020

Note 3.2 Income from patient care activities (by source)	2021/22	2020/21
Income from patient care activities received from:	**£000**	**£000**
NHS England	540	218
Clinical commissioning groups	13,393	7,215
Other NHS providers	372	194
Local authorities	1,494	19
Non NHS: other	3,591	507
Total income from activities	**19,390**	**8,153**
Of which:		
Related to continuing operations	19,390	8,153

Note 4 Other operating income

	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income As Restated	Non-contract income	Total As Restated
	£000	£000	£000	£000	£000	£000
Research and development	40	-	**40**	-	-	**-**
Education and training	169	46	**215**	66	-	**66**
Non-patient care services to other bodies	1,808		**1,808**	1,070		**1,070**
Reimbursement and top up funding	-		**-**	1,544		**1,544**
Charitable and other contributions to expenditure		-	**-**		55	**55**
Other income	-	-	**-**	-	-	**-**
Total other operating income	**2,017**	**46**	**2,063**	**2,680**	**55**	**2,735**
Of which:						
Related to continuing operations			2,063			2,735

* Non-patient care services to other bodies includes includes funding received specifically for the development of the organisation (£700k) and for delivery of non-clinical services transferred to the Trust from Dudley CCG (£1,017k). Income in respect of these services was recorded as "Other income" in the 2020/21 financial year, and are restated as Non-patient care services to other bodies in these accounts

Note 6.1 Operating expenses

	2021/22	2020/21
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	-	17
Purchase of healthcare from non-NHS and non-DHSC bodies	467	165
Staff and executive directors costs	16,118	7,459
Remuneration of non-executive directors	155	111
Supplies and services - clinical (excluding drugs costs)	19	61
Supplies and services - general	2	240
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	273	198
Consultancy costs	639	595
Establishment	817	316
Premises	92	13
Transport (including patient travel)	13	14
Depreciation on property, plant and equipment	21	13
Movement in credit loss allowance: contract receivables / contract assets	(2)	75
Increase in other provisions	50	27
Fees payable to the external auditor		
audit services- statutory audit	122	64
Internal audit costs	65	51
Clinical negligence	154	46
Legal fees	27	269
Insurance	56	30
Education and training	166	56
Rentals under operating leases	13	-
Other services, eg external payroll	1,543	903
Other	39	15
Total	**20,849**	**10,738**
Of which:		
Related to continuing operations	20,849	10,738

Other services includes: outsourced business intelligence and IT functions from other NHS organisations £676k, outsourced PMO support from other NHS organisations £180k, human resources, estates and information governance functions outsourced from other NHS organisations £279k and system risk share for the Black Country Integrated Care System of £280k.

Included within the audit services - statutory audit is £32k relating to 2020/21. All fees are inclusive of VAT

Note 6.2 Other auditor remuneration

There was no other auditor remuneration

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2 million (2020/21: £2 million).

Note 7 Employee benefits

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	10,961	4,936
Social security costs	1,011	402
Apprenticeship levy	36	5
Employer's contributions to NHS pensions	1,768	763
Temporary staff (including agency)	2,342	1,413
Total gross staff costs	**16,118**	**7,519**
Recoveries in respect of seconded staff	-	(60)
Total staff costs	**16,118**	**7,459**

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State 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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 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 also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially 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.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

c) Defined contribution schemes

The Trust also offers a defined contribution scheme under the National Savings Scheme (NEST). The Trust recognised contributions payable for the year in respect of this defined contribution scheme.

Note 9 Operating leases

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

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

	2021/22	2020/21
	£000	£000
Operating lease expense		
Minimum lease payments	13	-
Total	**13**	**-**

	31 March 2022	31 March 2021
	£000	£000
Future minimum lease payments due:		
- not later than one year;	14	-
- later than one year and not later than five years;	14	-
Total	**28**	**-**
Future minimum sublease payments to be received	-	-

Note 10 Finance income

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

	2021/22	2020/21
	£000	£000
Interest on bank accounts	2	-
Total finance income	**2**	**-**

Note 11 Finance expenditure

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

	2021/22	2020/21
	£000	£000
Interest expense:		
Other loans	69	109
Total finance costs	**69**	**109**

Note 12.1 Intangible assets - 2021/22

The trust did not hold any intangible assets during the year ended 31 March 2022

Note 12.2 Intangible assets - 2020/21

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2020	**5,766**	**5,766**
Valuation / gross cost at 1 April 2020	**5,766**	**5,766**
Transfers by absorption	(5,766)	**(5,766)**
Valuation / gross cost at 31 March 2021	**-**	**-**
Amortisation at 1 April 2020	**2,197**	**2,197**
Transfers by absorption	(2,197)	**(2,197)**
Amortisation at 31 March 2021	**-**	**-**
Net book value at 31 March 2021	**-**	**-**
Net book value at 1 April 2020	**3,569**	**3,569**

Note 13.1 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**-**	**-**	**-**	**2**	**-**	**64**	**10**	**76**
Additions	-	-	-	-	-	438	47	**485**
Valuation/gross cost at 31 March 2022	**-**	**-**	**-**	**2**	**-**	**502**	**57**	**561**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**-**	**-**	**-**	**-**	**33**	**4**	**37**
Provided during the year	-	-	-	-	-	20	1	**21**
Accumulated depreciation at 31 March 2022	**-**	**-**	**-**	**-**	**-**	**53**	**5**	**58**
Net book value at 31 March 2022	**-**	**-**	**-**	**2**	**-**	**449**	**52**	**503**
Net book value at 1 April 2021	**-**	**-**	**-**	**2**	**-**	**31**	**6**	**39**

Note 13.2 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020	**4,002**	**22,667**	**912**	**1,117**	**27**	**2,393**	**595**	**31,713**
Valuation / gross cost at 1 April 2020 - restated	**4,002**	**22,667**	**912**	**1,117**	**27**	**2,393**	**595**	**31,713**
Transfers by absorption	(4,002)	(22,667)	(912)	(1,115)	(27)	(2,329)	(585)	**(31,637)**
Valuation/gross cost at 31 March 2021	**-**	**-**	**-**	**2**	**-**	**64**	**10**	**76**
Accumulated depreciation at 1 April 2020 - as previously stated	**-**	**10**	**-**	**586**	**22**	**1,867**	**377**	**2,862**
Accumulated depreciation at 1 April 2020 - restated	**-**	**10**	**-**	**586**	**22**	**1,867**	**377**	**2,862**
Transfers by absorption	-	(10)	-	(586)	(22)	(1,846)	(374)	**(2,838)**
Provided during the year	-	-	-	-	-	12	1	**13**
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**-**	**33**	**4**	**37**
Net book value at 31 March 2021	**-**	**-**	**-**	**2**	**-**	**31**	**6**	**39**
Net book value at 1 April 2020	**4,002**	**22,657**	**912**	**531**	**5**	**526**	**218**	**28,851**

Note 13.3 Property, plant and equipment financing - 2021/22

	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000
Net book value at 31 March 2022				
Owned - purchased	2	449	52	**503**
NBV total at 31 March 2022	**2**	**449**	**52**	**503**

Note 13.4 Property, plant and equipment financing - 2020/21

	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000
Net book value at 31 March 2021				
Owned - purchased	2	31	6	**39**
NBV total at 31 March 2021	**2**	**31**	**6**	**39**

Note 14 Inventories

Inventories recognised in expenses for the year were £0k (2020/21: £55k). Write-down of inventories recognised as expenses for the year were £0k (2020/21: £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 2021/22 the Trust received £0k of items purchased by DHSC (2020/21: £55k).

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.

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

Note 15.1 Receivables

	31 March 2022	31 March 2021
	£000	£000
Current		
Contract receivables	1,487	1,887
Allowance for impaired contract receivables / assets	(8)	(85)
Prepayments (non-PFI)	13	30
VAT receivable	17	4
Other receivables	7	23
Total current receivables	**1,516**	**1,859**
Non-current		
Other receivables	14	-
Total non-current receivables	**14**	**-**
Of which receivable from NHS and DHSC group bodies:		
Current	1,056	1,339
Non-current	14	-

Note 15.2 Allowances for credit losses

	2021/22		2020/21	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**85**	**-**	**10**	**-**
New allowances arising	-	-	75	-
Changes in existing allowances	(2)	-	-	-
Utilisation of allowances (write offs)	(75)	-	-	-
Allowances as at 31 Mar 2022	**8**	**-**	**85**	**-**

Note 15.3 Exposure to credit risk

Credit Loss Provision - Local Authority Contract Receivables

	Gross	Lifetime	Lifetime
	£000	%	£000
Days past due date			
Current	0	1.19	0
1-30 Days	0	0.84	0
31-60 Days	0	0.01	0
61-90 Days	0	0.51	0
Over 90 Days	36	2.84	1
Total	**36**		**1**

Credit Loss Provision - Other Non-NHS Contract Receivables

	Gross	Lifetime	Lifetime
	£000	%	£000
Days past due date			
Current	10	2.68	0
1-30 Days	114	3.23	4
31-60 Days	0	0.08	0
61-90 Days	0	0.15	0
Over 90 Days	364	0.79	3
Total	**488**		**7**

Note 16.1 Cash and cash equivalents movements

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

	2021/22	2020/21
	£000	£000
At 1 April	**4,097**	**14,574**
Transfers by absorption	-	(13,132)
Net change in year	89	2,655
At 31 March	**4,186**	**4,097**
Broken down into:		
Cash with the Government Banking Service	4,186	4,097
Total cash and cash equivalents as in SoFP	**4,186**	**4,097**
Total cash and cash equivalents as in SoCF	**4,186**	**4,097**

Note 16.2 Third party assets held by the trust

Dudley Integrated Health and Care NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been included in cash and cash equivalents figure reported in the accounts and threre is corresponding liability included within payables."

	31 March 2022	31 March 2021
	£000	£000
Bank balances	31	32
Total third party assets	**31**	**32**

Note 17.1 Trade and other payables

	31 March 2022	31 March 2021
	£000	£000
Current		
Trade payables	1,102	807
Capital payables	47	-
Accruals	1,676	1,580
Social security costs	306	168
Other payables	240	405
Total current trade and other payables	**3,371**	**2,960**
Of which payables from NHS and DHSC group bodies:		
Current	1,047	1,318

Note 18 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income: contract liabilities	180	85
Total other current liabilities	**180**	**85**

Note 19.1 Borrowings

	31 March 2022 £000	31 March 2021 £000
Current		
Other loans	1,133	1,133
Total current borrowings	**1,133**	**1,133**
Non-current		
Other loans	567	1,700
Total non-current borrowings	**567**	**1,700**

Note 19.2 Reconciliation of liabilities arising from financing activities - 2021/22

	Other loans £000	Total £000
Carrying value at 1 April 2021	**2,833**	**2,833**
Cash movements:		
Financing cash flows - payments and receipts of principal	(1,133)	**(1,133)**
Financing cash flows - payments of interest	(69)	**(69)**
Non-cash movements:		
Application of effective interest rate	69	**69**
Carrying value at 31 March 2022	**1,700**	**1,700**

Note 19.3 Reconciliation of liabilities arising from financing activities - 2020/21

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

Note 20.1 Provisions for liabilities and charges analysis

	Other	Total
	£000	£000
At 1 April 2021	**27**	**27**
Arising during the year	67	**67**
At 31 March 2022	**94**	**94**
Expected timing of cash flows:		
- not later than one year;	53	**53**
- later than one year and not later than five years;	29	**29**
- later than five years.	12	**12**
Total	**94**	**94**

Other provisions include amounts relating to:
- £27k dilapidations of a premises occupied under an operating lease
- £2k public liability claims with an uncertain outcome
- £48k tax provision
- £17k clinician's pension tax reimbursement, for which a full reimbursement is expected and recognised in other receivables.

Note 20.2 Clinical negligence liabilities

At 31 March 2022, £1,652k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Dudley Integrated Health and Care NHS Trust (31 March 2021: £289k).

No new incidents were arising in the year ended 31 March 2022. All movements in provisions included by NHS Resolution relate to re-assessments of incidents that arose prior to the year ended 31 March 2022.

Note 21 Contingent assets and liabilities

	31 March 2022	31 March 2021
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(15.5)	-
Gross value of contingent liabilities	**(15.5)**	**-**
Amounts recoverable against liabilities	14.3	-
Net value of contingent liabilities	**(1.3)**	**-**
Net value of contingent assets	**-**	**-**

The Trust is currently defending DPA breach claim made against it, which is covered under the LTPS insurance scheme provided by NHS Resolution. The estimated gross liability is £15,500, with the probability-adjusted net contingent liability being estimated at 50% of the excess payable, less defence costs which have already been provided for.

Note 22 Financial instruments

Note 22.1 Financial risk management

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

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

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

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

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

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

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2022 are in receivables from customers, as disclosed in the trade and other receivables note.

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

Note 22.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	1,479	**1,479**
Cash and cash equivalents	4,186	**4,186**
Total at 31 March 2022	**5,665**	**5,665**

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

Note 22.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Other borrowings	1,700	**1,700**
Trade and other payables excluding non financial liabilities	3,065	**3,065**
Provisions under contract	29	**29**
Total at 31 March 2022	**4,794**	**4,794**

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

Note 22.4 Maturity of financial liabilities

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

	31 March 2022 £000	31 March 2021 £000
In one year or less	4,200	3,926
In more than one year but not more than five years	594	1,726
Total	**4,794**	**5,652**

Note 23 Related parties

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

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

	Income 2021/22 £000	Expenditure 2021/22 £000	Receivables 31 March 2022 £000	Payables 31 March 2022 £000
Future Proof Health Limited	-	333	-	3
Halesowen Medical Practice	464	47	-	1
Links Medical Practice	114	1	-	-
University of Wolverhampton	-	1	-	-
Eve Hill Medical Practice	-	3	-	-
HFMA	-	15	-	-
Keelinge House Surgery	-	4	-	-
Kerr Danley Ltd	-	10	-	-

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

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

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

Black Country Healthcare NHS Foundation Trust
Midlands Partnership NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust
Northern Care Alliance NHS Foundation Trust (formerly Salford Royal NHS Foundation Trust, acquired Pennine Acute Hospitals NHS Trust)
South Warwickshire NHS Foundation Trust
The Dudley Group NHS Foundation Trust
Shropshire Community Health NHS Trust
The Royal Wolverhampton NHS Trust
NHS Black Country and West Birmingham CCG
Health Education England
NHS Resolution
Supply Chain Coordination Limited
NHS Property Services
Community Health Partnerships
Department of Health and Social Care
NHS England
NHS Midlands & Lancashire Commissioning Support Unit

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

HM Revenue & Customs - VAT
HM Revenue & Customs - Other taxes and duties and NI contributions (Expenditure includes apprenticeship levy and employer NI contributions. Balances include both employer and employee contributions / PAYE deductions).

NHS Pension Scheme
National Employment Savings Trust (NEST)
Dudley Metropolitan Borough Council

Note 24 Transfers by absorption

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

The resulting transfer by absorption is detailed below:

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

Note 25 Prior period adjustments

In the 2020/21 accounts income received by the Trust in respect of non-patient care services provided to NHS Dudley CCG was recorded within Note 4 (Other Operating Income) as 'Other Income'. Income from NHS Black Country and West Birmingham CCG for the same services has been classified as "Non-patient care services to other bodies"in the 2021/22 accounts, and the 20/21 comparative data is restated against this category to provide consistency between financial years. This has had no impact on the overall value of income within Note 4, the Statement of Comprehensive Income or Statement of Financial Position.

Note 26 Better Payment Practice code

	2021/22 Number	2021/22 £000	2020/21 Number	2020/21 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	2,796	7,892	3,218	6,434
Total non-NHS trade invoices paid within target	2,785	7,865	2,677	6,054
Percentage of non-NHS trade invoices paid within target	99.6%	99.7%	83.2%	94.1%
NHS Payables				
Total NHS trade invoices paid in the year	189	4,453	187	14,402
Total NHS trade invoices paid within target	189	4,453	171	14,298
Percentage of NHS trade invoices paid within target	100.0%	100.0%	91.4%	99.3%

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

Note 27 External financing limit

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

	2021/22 £000	2020/21 £000
Cash flow financing	(975)	178
External financing requirement	**(975)**	**178**
External financing limit (EFL)	(975)	178
Under / (over) spend against EFL	**-**	**-**

Note 28 Capital Resource Limit

	2021/22 £000	2020/21 £000
Gross capital expenditure	485	-
Charge against Capital Resource Limit	**485**	**-**
Capital Resource Limit	488	-
Under / (over) spend against CRL	**3**	**-**

Note 29 Breakeven duty financial performance

	2021/22 £000
Adjusted financial performance surplus / (deficit) (control total basis)	537
Breakeven duty financial performance surplus / (deficit)	**537**

Note 30 Breakeven duty rolling assessment

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

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	1,960	2,199	3,384	3,054	1,629	38	537
Breakeven duty cumulative position	10,983	13,182	16,566	19,620	21,249	21,287	21,824
Operating income	64,546	66,293	69,482	74,340	81,986	10,888	21,453
Cumulative breakeven position as a percentage of operating income	17.0%	19.9%	23.8%	26.4%	25.9%	195.5%	101.7%

The breakeven cumulative net surplus of the Trust has exceeded 0.5% of operating income of the reporting year in every year of the breakeven period. The main reason for this is consistent delivery of in-year control totals as currently set by NHS Improvement. In 2021/22, the cumulative breakeven position as a percentage of operating income has decreased significantly, which is as a result in the significant increase in operating income following the full year effect of services transferred from Dudley CCG in 2020/21 and the transfer of services from Shropshire Community Health NHS Trust in 2021/22.

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