Dudley Integrated Health and Care NHS Trust

DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

WEDNESDAY 8 SEPTEMBER 2021
INSPIRATION 2, THE VILLAGE HOTEL, DUDLEY, DY1 4TB
10.30 – 13.00

PUBLIC AGENDA

Please note, as part of DIHC's commitment to openness and accountability, members of the public are able to join the meeting via MS Teams, but will need to notify in advance to do so as the link for the meeting will not be available on the public website. Should you wish to join the meeting please email Elaine Doyle, Trust Secretary on elaine.doyle6@nhs.net who will provide details and guidance on observing the meeting. Should you wish to ask a question about the issues on the Board Agenda please send your question prior to the meeting. The papers, minutes and any questions and answers to the items on the Board Agenda will be published on the DIHC website.
Equipment, technical advice or support for members of the public wishing to observe the meeting cannot be provided.

Item No	Agenda Item			Presented by	Time
Formalities: to declare the meeting open, quorate and in accordance with the standing orders:					
1.	**Chair's Welcome**		Verbal	Mr H Turner	10:30
	1.1 Apologies	To Receive	Verbal	Mr H Turner	
	1.2 Declarations of Interest	To Receive	Verbal	Mr H Turner	
	1.3 Board of Directors' Register of Interests	To Receive	Enclosure 1.3	Mr H Turner	
	1.4 Public Board Minutes – meeting held on 6 July 2021	For Approval	Enclosure 1.4	Mr H Turner	
	1.5 Action Register and Matters Arising	For Approval	Enclosure 1.5	Mr H Turner	
2.	**Service Story**				
	2.1 Respiratory Assessment Centre – Learning from Covid	For Information	Verbal	Ms B Wakelam	10:35
3.	**Standing Items**				11:15
	3.1 Chair's Update	For Information	Verbal	Mr H Turner	
	3.2 Chief Executive's Report	For Information	Enclosure 3.2	Ms S Cartwright	
	3.3 Agenda for Part Two – Private Board	For Information	Enclosure 3.3	Mr H Turner	
Our Services					
4.	**COVID19 – Vaccination & Recovery**	For Assurance	Verbal	Dr L Martin/ Dr R Bramble	11:25
5.	**Board Assurance Framework & Corporate Risk Register**	To Review	Enclosure 5	Ms E Doyle	11:30

Item No	Agenda Item			Presented by	Time
Delivering safe and quality services, supported by integrated governance that drives quality clinical improvements					
6.	**Report from Medical Director**	For Assurance	Enclosure 6	Dr L Martin/Dr R Bramble	11:35
7.	**Quality and Safety Performance Report**	For Information	Enclosure 7	Ms S Nicholls	11:40
8.	**Quality and Safety Committee Assurance Report**	For Assurance	Enclosure 8	Ms V Little	11:45
The best place to work, supported by a new leadership and workforce culture, organically co-developed, together					
9.	**Workforce Performance Report**	For Information	Enclosure 9	Ms B Edgar	11:50
10.	**People Committee Assurance Report**	For Assurance	Enclosure 10	Mr M Evans	11:55
11.	**Equality, Diversity and Inclusion**	For Information	Enclosure 11	Ms B Edgar	12:00
Doing the best with what we have, to be affordable today and sustainable tomorrow					
12.	**Finance, Performance and Digital Report**	For Information	Enclosure 12	Mr M Gamage/ Mr P King	12:05
13.	**Finance, Performance and Digital Committee Assurance Report**	For Assurance	Enclosure 13	Mr I Buckley	12:10
Help and Empower the People of Dudley to live longer and healthier lives through fully integrated community based healthcare					
14.	**Report from the Primary Care Integration Committee**	For Assurance	Enclosure 14	Dr G Solomon	12:15
15.	**Report from the Transaction and Transformation Committee**	For Assurance	Enclosure 15	Ms S Cartwright	12:20
Governance and Assurance					
16.	**20/21 Annual Report and Accounts**	For Approval	Enclosure 16	Mr H Turner	12:25
17.	**Quality Account**	For Approval	Enclosure 17	Ms S Nicholls	12:35
18.	**Audit and Risk** Report from Extraordinary Audit and Risk Committee	For Assurance	Verbal	Ms V Little	12:40
End of Meeting Formalities: to bring the meeting to an end and include reflections on the meeting before inviting an opportunity for questions from the public. Normally pre-submitted in advance of the meeting and answered during the allotted time or in writing following the meeting.					
19.	**Any Other Business**		Verbal	Mr H Turner	12:45
20.	**Questions from the public** – pre-submitted	To Receive	Verbal	Members of Public	12:50
21.	**Risk Review**		Verbal	Mr H Turner	12:55
22.	**Date of next meeting:** 5 October 2021, 09.30 – 12.00 Venue TBC				

Enclosure 1.3

Dudley Integrated Health and Care NHS Trust
Declaration of Interest Register

NHS Dudley Integrated Health and Care NHS Trust

Title	Name	Job Title/Relationship with Dudley Integrated Health and Care NHS Trust	Declared Interest	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To
Ms	Bev Edgar	Interim Associate Non-Executive Director	Trustee at The Hospice Charity Partnership		✓			Aug 2021	
			Trustee at BHS Trust Fund			✓		Feb 2021	
Ms	Billie Lam	Associate Non-Executive Director	Volunteering for Staffordshire Healthwatch			✓		Apr 2019	
			Registered as a bank staff at Kettering General Hospital NHS Foundation Trust	✓				Mar 2020	
			Member of Seacole Group		✓			Jun 2021	
			Attending Inclusion Council and North Staffordshire ICP Stakeholder Group meetings at North Staffordshire Combined HC Trust		✓			Jul 2021	
Mr	David Gilburt	Non-Executive Director & Audit Chair	Chair of Cheshire PCC and Chief Constable's Joint Audit Advisory Committee.	✓				2017	
			Non-Executive Director and Audit Chair of the Robert Jones & Agnes Hunt NHS FT	✓				2015	
			Member of the HFMA Governance & Audit Committee		✓			2018	
			Member of the Audit Committee of the Muir Group Housing Association	✓				Feb 2021	
Dr	George Solomon	Non-Executive Director	Partner is a Non-Executive Director of Walsall Healthcare NHS Trust				✓	Apr 2020	
			Volunteer COVID Vaccinator SWL PCN, Dudley		✓			Feb 2021	

Title	Name	Job Title/Relationship with Dudley Integrated Health and Care NHS Trust	Declared Interest	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To
Dr	Gillian Love	Associate Non-Executive Director	GP Partner Halesowen Medical Practice		✔	✔		1996	
			Clinical Director of Halesowen PCN		✔			2019	
			Director of Future Proof Health		✔			Jan 2020	
			Share Holder of Future Proof Health		✔			Aug 2014	
			Director of Mary Martin Enterprise Ltd					2014	
Mr	Harry Turner	Chairman	Deputy Chair S.I.D Robert Jones Orthopaedic Hospital	✔				Jan 2017	
			Chair – The Hospice Charity Partnership		✔			Aug 2021	
			Intercontinental Hotels – Consultant	✔				Aug 2006	
			Presiding Magistrate Worcestershire				✔	2005	
Mr	Ian Buckley	Non-Executive Director	N/A						
Dr	Lucy Martin	Acting Joint Medical Director	Partner Eve Hill Medical Practice	✔				2001	
			Shareholder Futureproof Health		✔			Aug 2014	
			Board member Stourbridge Lawn Tennis and Squash Club			✔		Oct 2020	
Mr	Martin Evans	Non-Executive Director	N/A						

Title	Name	Job Title/Relationship with Dudley Integrated Health and Care NHS Trust	Declared Interest	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To
Mr	Matthew Gamage	Interim Director of Finance	CIMA Member		✓			2012	
			Currently seconded to Interim Director of Finance role from Dudley CCG		✓			Apr 2020	April 2022
Mr	Paul Assinder	Interim Chief Executive Officer	Non-Executive Director of Walsall Healthcare NHS Trust	✓				Nov 2019	
			Director of Rodborough Consultancy Ltd (providing financial consultancy to NHS and other clients)	✓				Jun 2014	
			Honorary Lecturer, University of Wolverhampton (unpaid)		✓			2012	
			Governor of Solihull College & University Centre (unpaid)			✓			
Mr	Philip King	Interim Chief Operating Officer	Visiting lawyer and lecturer, Birkbeck School of Law, University of London	✓				Sept 2002	
			Member of Liberty Lawyers Group		✓			Sept 2002	
			Member of The Inner Temple		✓			Sept 2000	
			Registrant Member of the Bar of England and Wales		✓			Sept 2002	
			Member of the Royal College of Nursing		✓			Jan 1987	
			Director of Audenmark Ltd	✓				Jan 1993	

Title	Name	Job Title/Relationship with Dudley Integrated Health and Care NHS Trust	Declared Interest	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To
Dr	Richard Bramble	Acting Joint Medical Director	GP Partner, Links Medical Practice	✔				2013	
			Shareholder, Futureproof Health	✔				2015	
			Revival Fires Church			✔		2008	
Mrs	Stephanie Cartwright	Director of Operations, Strategy and Partnerships for Dudley Integrated Health and Care NHS Trust (Internal Secondment)	Currently seconded to Interim Executive Director role from Dudley CCG		✔			Apr 2002	April 2022
			Married to the Chief Executive Officer of Black Country and West Birmingham CCGs			✔		Mar 2020	
Dr	Stephen Cartwright	Associate GP Non-Executive Director	Partner GP - Keelinge House Surgery	✔	✔			1991	
			Part owner of Keelinge House Building	✔				1998	
			Shareholder of Future Proof Health	✔				Aug 2014	
Ms	Valerie Ann Little	Non-Executive Director	Vice Chair of Corporation of Dudley College of Technology		✔			Sep 2019	
			Member of the Corporation of Dudley College of Technology		✔			Jan 2016	
			Member of the Board of Care & Repair England		✔			Jun 2015	

Enclosure 1.4

Dudley Integrated Health and Care NHS Trust

DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

MINUTES OF THE PUBLIC MEETING HELD ON 6TH JULY 2021
09:30 – 12:20 hours
VIRTUAL MEETING VIA MICROSOFT TEAMS

Mr H Turner (HT)(Chair)	Chairman, DIHC
Mr P Assinder (PA)	Interim Chief Executive, DIHC
Ms C Brunt (CB)	Interim Director of Nursing & Allied Health Professionals, DIHC
Mr I Buckley (IB)	Non-Executive Director, DIHC
Mrs S Cartwright (SC)	Interim Director of Operations, Strategy and Partnerships, DIHC
Dr S Cartwright (STC)	Associate Non-Executive Director, DIHC
Mrs E Doyle (EFD)	Trust Secretary, DIHC
Mrs B Edgar (BE)	Interim Associate Director of People, DIHC
Mr M Evans (ME)	Non-Executive Director, DIHC
Mr M Gamage (MG)	Interim Director of Finance, DIHC
Mr D Gilburt (DG)	Non-Executive Director, DIHC (from item 8)
Ms B Lam (BL)	Associate Non-Executive Director, DIHC
Ms V Little (VL)	Non-Executive Director DIHC
Dr G Love (GL)	Associate Non-Executive Director, DIHC
Dr L Martin (LM)	Acting Joint Medical Director, DIHC
Dr G Solomon (GS)	Non-Executive Director DIHC

In Attendance:

Ms H Ashby (HA)	Observer (items 1 – 15)
Mr R Dalziel (RD)	Participatory Research Officer, Healthwatch Dudley (observer) (from item 2)
Ms K Darby (KD)	School Nurse, DIHC (presenter) (item 2 only)
Ms G Hooper (GH)	School Nurse, Team Leader (presenter) (item 2 only)
Mrs J Ilic (JI)	Communications Advisor, DIHC
Mrs S Nicholls (SN)	Deputy Director of Nursing, DIHC
Ms E Thrupp (ET)	School Nurse, DIHC (presenter) (item 2 only)
Ms K Weston (KEW)	Interim Executive Assistant (minutes)
Ms K Wright (KW)	Director of Public Health & Wellbeing (observer, items 1 – 8)
Mr J Young (JY)	Associate Director of Quality and Governance, DIHC

Item No.	Agenda Item
1.	**Chair's Welcome**
	The Chair welcomed everyone to the meeting and formally welcomed BL who has recently joined the Trust as an Associate Non-Executive Director.

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	1.1 Apologies Apologies were noted from David Gilburt at the beginning of the meeting and from Dr Richard Bramble. DG joined the meeting from item 8. **1.2 Declarations of Interest** GS declared that he is registered on the ICS Vaccination Bank. **1.3 Board of Directors' Register of Interests** The Board noted the register of interest. It was noted that BL's interests will be added to the register, and BL confirmed that there are no declarations to raise today. **1.4 Public Board Minutes – meeting held on 3 June 2021** Item 17, paragraph three to read 'DG raised that the committee were unable to review the draft annual report and DG provided a note of thank you to the Executive Team for subsequently producing this report.' Following the slight amendment as noted above, the minutes were agreed as an accurate record. **1.5 Action Register and Matters Arising** PUB/MAY21/001 – SC confirmed that Cluster Connect are joining the Primary Care Network (PCN) Clinical Directors meeting on 14 July 2021. **Action closed.** PUB/JUN21/001 – The declaration of interest register has been updated. **Action closed.** PUB/JUN21/002 – CB assured that this is action is being taken forward with the Safeguarding team. **It was agreed to close this action.** PUB/JUN21/003 – SC assured that the operational leads are working with Molly Glynn and that the plans will be presented through Committees over July and August. Once agreed, the operational service delivery plans will be added to the business plan and the updated business plan will be presented to a future Board. **Action closed.**
2.	**Service Story**
	2.1 School Nursing Service HT welcomed the school nurses and commented how delighted they are that the service has transferred to the Trust. HT commented that it was a pleasure to work with the team and Shropshire Community Health NHS Trust on this transfer. SN welcomed Gail Hooper, School Nurse Team Leader and Karen Darby and Eve Thrupp, School Nurses to the meeting and noted that the Board will hear about the difference that the team is making with children and young people. It was noted moving forward the transformational work that the team will be doing across Dudley to cement the 0-19 agenda will be pivotal to the Trust's work to improve population health outcomes.

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	SN highlighted that there are some challenges in the team and these are challenges that are being born out across England. GH provided the Board with an overview of the history of school nursing and an overview of the team. The team consists of 25 Registered Nurses with the Nursing and Midwifery Council (NMC), five School Nurses Support Workers and three Admin staff. There are quite a few vacancies within the team which are being recruited to although it was acknowledged that this is a national issue. The School Nurse role is to improve the health and wellbeing of children and young people and they are responsible for delivering programmes to improve health outcomes for school aged children and young people. There are 104 schools in Dudley and the caseload each school nurse can be responsible for is anything between 600 and 2500 pupils. It was noted that since the pandemic, the School Nurses will be an essential part of the response to recovery. GH stated that the team are seeing more children who need support for different issues since the pandemic started. ET and KD provided two personal stories which were published as part of the Queens Nursing Institute. KD commented that the pupil she worked with she saw a few years later and was introduced as 'the woman who changed her life'. HT provided a note of thank you for the two fantastic stories and also provided a note of thank you on behalf of the Board and the people of Dudley for the amazing work of the School Nurses. LM queried what GH, KD and ET's thoughts are around integrating mental health workers into schools. All confirmed it would be very helpful to be able to work closely with mental health workers in schools. GH added that there are going to be Educational Mental Health Support Workers in post in around 20 schools in Dudley which will be a link with the school Mental Health Lead, mental health services and the school nursing service. SC queried if there is any more the Trust can do for the team now they have joined the organisation. GH responded that the safeguarding element is enormous schools have a large number of children on child protection plans and also children who are in care. These children do require extra care and support. There are challenges appointing staff as there are a lot of vacancies across Birmingham and Sandwell. The Trust will look to help with recruitment. It was also noted that a lot of nurses are based in schools and do not have a space big enough where they can all meet together. SC responded that Mike Nicklin the Trust's interim Estates Lead is looking at accommodation to use as a base so that the School Nurses can come together as a team. BL queried if there are any challenges with pupils from a BAME background or those in hard to reach groups. ED responded there is no barrier or challenge as pupils see the school nurses as part of the community. It was noted that some pupils have English as their second languages however there are staff in schools who are able to help communicate with the pupils and their families, or the service can bring in an interpreter. ME queried how GH manages the demand on the team versus the resource and capacity the team has, and how GH would raise any concerns. GH responded that if there are any concerns she would raise this with SN who is managing the services and also the Local Authority. The service helps parents and families to enable them to support their children however it was noted that the demand in the service has increased following the pandemic and there is now a waiting list for children.

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	It was agreed the Board will discuss outside of the meeting how to keep oversight on demand and performance. KW commented on the connection with local communities in the vicinity of the schools, and queried whether more needs doing in this area of work. KD responded that she joins the Cluster Connect meetings which brings together different agencies and is also part of the Dudley Covid group to understand what is happening in the local community. VL raised that the Trust need to be mindful that only certain schools in Dudley have a sixth form and that many children move onto colleges after year 11. VL stated there is not a mandate to have a team in relation to college students and GH responded that there is a gap in the service for 16 – 19 year olds is a gap in the service. 16+ year olds tend to use the KOOTH service. It was noted a number of the school nurses have a Public Health qualification and MG queried what this enables the nurses to do and what Public Health issues there are still in schools. GH responded that qualified nurse would go to university for 12 months on a college basis to do further in depth work around school health. Some of the issues, emotional health, risky behaviours, childhood sexual exploitation, gang involvement etc. Anxiety is the most common 'thing'. GS queried if there have been any challenges with children with learning disabilities coming back into schools and any post-lockdown challenges. KD commented that attendance dropped considerably, did do home visits to the families when schools were not open. More children are anxious about health and that the team need to work with children to gain the level of trust to reassure that they are safe when at school. STC asked if the School Nurses have chance to educate year groups on healthcare, around how to use the health service etc. GH responded that yes the nurses educate year groups however schools ask for different topics to be covered as there is not one standard approach across all schools. The School Nurses are trying to get all schools to have the same health promotion sessions. GL commented that there are other organisations such as Hear4Youth, Phase Trust and The What Centre. It was noted that Primary Care, Mental Health, School Nurses and the Voluntary Sector need to link together to help young people. HT highlighted that they met with one of the MPs who is Secretary of State for education and they were interested in the model of care from an education point of view. Subject to treasury they are keen to do some different approaches around the integration model and HT and PA have offered to work with him on this matter. HT on behalf of the Board provided a note of thank you to GH, KD and ET for their presentation/ It was agreed for some of the team to speak to staff who are transferring to the organisation in the future to provide their experience.
3.	**Standing Items**
	3.1 Chair's Update HT reported that he and PA have been meeting with MPs and other politicians who are all supportive of what the Trust are trying to achieve around population health.

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HT and STC visited the Respiratory Assessment Centre on its last day of operation on 30 June 2021 and passed on a note of thank you to the team for all of their hard work. It was discussed for the team to join a future board meeting to talk about their experience and for the Board to have an opportunity to provide a note of thank you.

It was confirmed that the Non-Executive Director appraisals are complete and will be submitted to NHSE/I.

HT stated that they met with the Regional Director from NHSE/I with Dr Ruth Edwards and assured the Board that the conversation held during the meeting was positive.

It was noted that HT on behalf of the Board has written to the new Secretary of State for Health and Social Care to congratulate him, to describe the Trust's model and providing an invite for the Secretary of State to visit and meet with members of the Board to find out more.

The Board noted the Chair's update.

3.2 Chief Executive's Report

PA reported there has been an increase in infections of Covid19 both nationally and locally and currently the infection rate in Dudley from Covid19 is around 185 per 100,000 population.

The correlation between Covid infections and hospital admissions appears to be much weaker which PA stated is important to note.

As mentioned in the Chair's update the Respiratory Assessment Centre closed at the end of June. At its height the Respiratory Assessment Centre cared for 15 to 16 people per day which made a real contribution to the local Covid response and contributed to keeping people out of A&E and GP practices. The Board acknowledged the amazing work of the team.

It was noted that the Primary Care based services will not be restored at this facility straight away to enable the centre to reopen if required. When the Trust is more confident that the facility will not be needed, the Trust will engage with the local population around restoring primary care services in Pensnett.

Numbers continue to increase with regards to vaccination rates. Across the Black Country and West Birmingham in total 90% of people aged 45 and over and around 83% of those over 25, have now been vaccinated and Dudley continues to set the standard.

PA provided a note of thank you to colleagues in Primary Care and Dudley Integrated Health and Care NHS Trust (DIHC) Teams, who have worked so hard to protect our local community.

It was noted that the NHS is seeing, across the country, a lot of people presenting with ongoing symptoms of Covid from five weeks after the infection and others presenting with a whole range of post-covid physical and psychological impacts, more than 12 weeks after contracting the virus. There has been a release of a Long Covid Strategy from the NHS. The strategy includes a five-point plan which is included in the CEO report.

On 12 May the Prime Minister announced a public enquiry into the government's handling of the Covid19 pandemic. Health organisations are now working to secure the information that recorded decision making over the past 15 months and in DIHC JY and EFD are undertaking this work. This will record Covid strategy related decisions that have been made, so the Trust is ready if called upon as part of the national enquiry. The Trust is working closely with Black Country

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Healthcare NHS Foundation Trust (BCH) which provided 'major incident support' under our SLA, throughout the pandemic.

PA reported that the NHS was awarded the George Cross for 73 years dedicated service, by Her Majesty the Queen. Locally the Trust celebrated the 73rd anniversary with a Mad Hatters virtual Tea Party.

From 1 July 2021, the NHS Prompt Payment Code has been strengthened so that 95% of payments to Small and Medium Enterprises (organisations with less than 50 employees) must be paid within 30 days (for larger companies the 60-day payment limit will stay in place). The Trust measure payments against the 30 day payment limit and is assured that it continues to pay all suppliers promptly.

In October 2020, the NHS became the world's first national health system to commit to net zero Emissions and there are ambitious targets for the NHS to meet. The NHS has been through a huge data collecting exercise and a detailed green plan has been released which the Trust is looking at. The Trust will be building the organisation with good green credentials and will keep it at the forefront of its working going forward.

HT and PA attended the Black Country and West Birmingham Annual General Meeting on 24 June 2021 and Dr Ruth Edwards, Chair of Dudley Clinical Commissioning Committee, reported that the successful establishment of DIHC was one of the System's highlights of 2020/21.

PA reported the Trust has launched the recruitment process for a new Board position of Chief Operating Officer and the Trust are receiving significant interest in the role.

It was noted that there have been highly successful meetings with new Dudley Councillors and our local members of Parliament. Key themes include a real support for DIHC and for the benefits of integrated care in Dudley, as well as commitment to continued engagement in the future.

IB asked for an update on the Black Country and West Birmingham Integrated Care System (ICS).

PA responded that the place- based model is increasingly becoming embedded and the four acute trusts across the Black Country are having much more meaningful dialogue around the extent that they can work together and plan services across the totality of the Black Country. This trend is coming through in the STP-wide restoration and recovery work. There is also work ongoing with the Dudley Partnership Board which is working around the Dudley place with all partners included in these meetings. It was noted that the Partnership Board will evolve and is currently going through a development programme to become the Place Based Partnership Board.

SC added that the Mental Health lead provider work is also progressing at pace.

It was noted that the biggest challenge from the planning and recovery is organisations making the transition to plan for a system. All the intelligence suggests the legislation changes will go ahead as planned.

The Board noted the Chief Executive's report.

3.3 Agenda for Part Two – Private Board

The Board noted the agenda for part two.

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4.	**COVID19 Response – Vaccination Update**
	Covered under previous items.
5.	**Board Assurance Framework and Corporate Risk Register**
	EFD reported that there is one risk recommended for closure C-108, following review at the Quality and Safety Committee. There was a thorough piece of work undertaken in December 2020 and an assurance paper was taken to the committee which looked at the risks exposed on procurement, supply of medicines, workforce etc. The Committee then reviewed the risk following the EU exit and it is now recommended for approval for closure. It was highlighted that six risks have been developed in conjunction with the Primary Care Integration Committee. A series of risk workshops have been held followed by a detailed discussion at Committee, and the latest position has been reflected in the scores and mitigations. EFD asked the Board for support to add the risks to the corporate risk register. The Board were in agreement to close risk C-108 and supported adding all six risks that have been developed with the Primary Care Integration Committee. EFD reported that they have been meeting with Executive Directors and developing the Board Assurance Framework (BAF). The BAF will be going to the Executive Committee in its final draft form and will then go through Committees in July and August. It was noted that there are very small changes to the BAF as it was developed in January 2021. The Board Seminar on the 30 June 2021 approved the tolerances and the risk appetite statement, and EFD is aligning the strategic objectives to the current BAF. The spider diagram in the report shows that average risk score of a number of risks aligned to the strategic objectives, where the bars are closer together there is lower level of risk tolerance within that risk portfolio and therefore, these risks need to be actively managed to prevent the risk portfolio going above tolerance. It was noted that the Trust has researched dyslexia friendly and easy to interpret colours and have gone with the Making Data Count and wider NHS guidance using orange, blue and grey. Work continues as pace on implementing the risk module within Datix. EFD and JY are developing a training programme, and Internal and External Auditors have reviewed the guidance to ensure that it is fit for purpose. **The Board agreed agreement to close risk C-108 and supported adding all six risks that have been developed with the Primary Care Integration Committee.**
6.	**Report from Medical Director**
	The paper was taken as read and LM noted that work is progressing around the Quality Impact Assessment (QIA) for the transfer of community services from The Dudley Group NHS Foundation Trust (DGFT) to DIHC and relationship work is continuing with outside stakeholders and partners.

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	ME commented they are pleased to read that practice engagement visits are being carried out to address where the Trust can influence and support, and queried if there is any examples of what practices have asked for support with. LM responded that a few different areas have been highlighted during the visits including GP sustainability and estates. In regards to estates this will be worked through as the Trust develops the full integration plan. The Trust have been trying to support practices with the way it implements the Standard Operating Procedure (SOP) following the Covid changes. The Head of Primary Care has been coordinating an approach to try and get a Dudley perspective so Dudley can adopt the SOP with a united approach. SC added that the Trust have recently had enquiries from practices around additional support, and raised that the Trust will need to invest and expand the primary care team. It was noted having practice management moving forwards is essential and to ensure that when engaging with practices that all members of staff are able to have a voice not just the lead GP. LM highlighted that one of the important threads when having conversations with DGFT staff who are planned to transfer to the Trust is the way to integrate Practice Nursing and Community Nursing in a much more cohesive way. The practice nurses work closely with Joanne Taylor (Strategy and Transformation Lead for the Trust) and SN links in with the STP/ICS work around work with Practice Nurses. Alongside that is the AHP workforce which the Trust is engaging with more. LM stated the multi-disciplinary team and the contribution they can all make is crucial. **The Board noted the Medical Directors report.**
7/8.	**Quality and Safety Performance Report/ Quality and Safety Committee Assurance Report**
	CB reported that there are no concerns to escalate to the Board. The previously reported serious incident has had a thorough review, has been submitted to the CCG, and has been signed off and closed on STEIS. CB commended the team who have worked on the review process and provided significant assurance. Work continues to strengthen the DIHC safeguarding infrastructure and CB stated that the Trust are currently advertising for a Safeguarding Practitioner – Adults and Children's. The Trust are in a positive position in regards to the vaccination of staff with a total of 89% of staff vaccinated which includes both patient facing ad non-patient facing. VL raised that the Trust need to continue to promote the vaccination and start to think of innovative ways to do this as restrictions begin to ease and infection rates are starting to increase. In regards to Health and Safety, a work plan for 2021/22 has been developed which includes bringing Health and Safety management fully in-house. Priority tasks relate to Covid workplace risk assessments in preparation for a return to face to face clinical work, together with a review and refresh of other core risk assessments. It was noted the Trust will be building up the infrastructure when bringing this fully in-house and ensuring that it is robust for when the organisation grows and operates from more premises. VL assured that the Quality and Safety reviewed the risk register and provided a note of thank you for the Board agreeing with the Committees recommendation for the closure of risk C-108.

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	The Committee made a decision to delegate the final tweaks to the Quality Account to the Interim Director of Nursing, AHPs and Quality and the Associate Director of Quality & Governance. The Quality Accounts have now been agreed and submitted. It was highlighted that there are three out the four patients in care home who have not received the second dose for the vaccine and BL queried if there is any issue in ensuring the patients receive this. GS also added the second dose uptake in general is consistently lower than the first dose uptake, and queried if is there an issue with people coming for their second dose. VL responded that this was a query at a previous committee. It was noted that individuals may not be in a position to accept the vaccination due to their medical condition, they may have become positive after their first dose which means there is a delay in them receiving their second dose, or individuals may have been taken into hospital. CB added that there has been no one for recall at the care homes so it is possible that sadly the resident has passed away. GL also raised that there is an issue with people wanting the second vaccination particularly AstraZeneca because of the bad press and the number of side effects some people have experienced. It was queried if there are any thoughts to address the likely fear that may be expressed by staff around returning to work. CB responded that they recognise the anxieties and assured that returning to work will be done in a sensible and phased way. There will be individual and service considerations that will be factored in. SC added that a return to a regular corporate environment will not be until September when the office is established to allow this. The vast majority of organisations are going to adopt an agile working perspective and agile working will be promoted. All services are restored but undertaking a mixture of face to face and virtual service delivery which will continue. KW emphasised the importance to remind people to follow the rules and get vaccinated. JY helpfully added that the Trust are working closely with colleagues at BCH around Health and Safety (H&S) as the Trust has a Service Level Agreement in place with them to provide H&S support. JY has also been working with the school nursing team around H&S and helping them to manage their risk assessment. It was noted that it has been a positive experience and the have been really engaging. GL raised there needs to be thought given to how to protect public and staff when restrictions ease. **The Board noted the Quality and Safety Performance and Assurance report.**
9/10.	**Workforce Performance Report/ People Committee Report**
	BE reported the funded establishment for May 2021 was 265.43 Whole Time Equivalents (WTE). The Trust have 330 staff and the number has now increased by more than 50 as the Practice Based Pharmacists transferred on 1st July 2021. The committee gave recognition and thanks for the significant work undertaken by the HR team throughout this transfer process. It was noted there are two cases of long-term sickness which the Trust are managing and will support the individuals to get to a resolution.

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	The Trust are having conversations with BCH around the availability of moving back to face to face training. It was noted that the Trust have identified another provider who will also be able to carry out training if required. The Trust has been requested to add an additional mandatory training module to all staff in the NHS which is known as Prevent. It is an online training programme to make sure staff are aware of the dangers of radicalisation and terrorism. ME assured the committee reviewed their risk register and no amendments were made. The committee had good discussions around current risk and relevant detail which needs to be included within the realignment and refresh of the BAF strategic risks. The committee received an update on Organisational Development and work continues on the new People strategy and Organisational Strategy. There is an extraordinary meeting in August to go through the detail. Assurance was provided regarding the focus and progress of recruiting to vacancies including those for Improving Access to Psychological Therapies (IAPT) and the Primary Care Network. It was acknowledged that there will likely be a further increase in Primary Care Mental Health (PCMH) vacancies over the coming weeks due to a number of staff applying for other roles that have become available. Work is ongoing to refresh and refocus the PCMH team and a further update will be provided at the next meeting. This is also being discussed at the Quality and Safety Committee. The committee reviewed the mandatory training compliance and agreed that the current levels of compliance were not as high as should be expected. It was acknowledged by the committee that more work is required, and this is being taken forward by the Executive team and will be reviewed at the next meeting. **The Board noted the Workforce Performance Report and People Committee Assurance Report.**
11.	**Equality, Diversity and Inclusion**
	The report was taken as read. BL commented that they were invited to observe this meeting and it was a positive meeting with good work being taken forward. GS highlighted that the report notes a presentation from colleagues at Black Country Healthcare NHS Foundation Trust on the Learning from the Impact of Covid-19 on the Learning Disabilities Community. GS commented that they would value sight of the presentation once complete and it was agreed this will be shared once available. **The Board noted the Equality, Diversity and Inclusion report.**
12/13.	**Finance, Performance and Digital Report/ Committee Assurance Report**
	MG reported the year to date surplus is being achieved of 9k for month two which is forecast to be 14k for year end. The Trust are on track to deliver against plan. It was noted that the Trust have a healthy cash balance of just under four million.

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	MG stated that the Trust paid all suppliers within the expected threshold for May and therefore had a 100% achievement. IB assured the Board that there will be a greater emphasis on workload for the Business Intelligence department as the organisation builds up its strategic plans moving forwards. HT commented he is aware of a new way of measuring performance in the NHS and whether the Trust should look into adopting a new approach. It was agreed for MG and IB to consider this outside of the meeting. **The Board noted the Finance, Performance and Digital Performance and Assurance Report.**
14.	**Report from Primary Care Integration Committee**
	The committee was held on 16th June 2021 and GS reported that the annual work plan is on track. There is a project structure and funding available to support the full integration work stream which has been agreed by the Executive team, and practice engagement visits had commenced. The SLA between DIHC and the PCN's for the Additional Roles Reimbursement Scheme (ARRS) was discussed at the committee. GS confirmed that the SLA is now agreed and needs to be signed, the Head of Primary Care is coordinating this. The committee received an update on the decommissioning of the Respiratory Assessment Centre and that DIHC would continue to provide oximetry at home on behalf of PCNs who have agreed to continue to fund this element. GS stated that the committee also received an update on the planned public consultation taking place regarding the future of High Oak surgery. It was noted that a proposal under any other business was considered at the committee to align the income protection for the Local Improvement Schemes and a recommendation has been made to the Finance, Performance and Digital Committee. **The Board noted the Primary Care Integration Committee report.**
15.	**Report from Transaction Committee**
	SC reported that the team are currently working through a process with DGFT regarding the transfer of community services and an immense amount of work has been progressed in the last two to three weeks. SC provided a note of thank you to the team. It was noted that this process will be concluded following the input of the Clinical Senate on the 21 July, where they will review the transfer of services and the Trust will have complete clarity towards the end of July/beginning of August. In regards to the transfer of children's services from BCH to DIHC, the transfer meetings are starting imminently and project support is in place. The Trust are working to an October submission of the business case and have regular contact with NHSE/I.

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	SC reported that the Business Case Engagement Forum has met in its new form with an Independent Chair chairing this meeting. The previous meeting started with two patient stories to bring the work of the business case to life and this was well received by the Forum. SC stated that the invitation to this meeting has been extended to Non-Executive Directors from DGFT and BCH. The business case risk register was taken through the Engagement Forum and the Trust have not received any comments from partners. Changes will be made to the register as work progresses. The Board were assured that work is progressing well with the CCG with regards to the population of the ICP contract. Due diligence letters and requests being sent out this week for the service transfers and the Trust are working with Browne Jacobson on this. SC stated it is important to get this process underway to complete the timescales for the business case. The Development Plan and business case milestones were discussed at the last committee and it was noted the DIHC development group has reformed to be an action focused meeting around the business case. The Trust are bringing in additional support to be able to complete the case and a meeting was held last week to identify any gaps. Due to the lockdown restrictions, it was noted that the Trust have not had the opportunity to develop networks as it moves to the submission of the business case. As lockdown restrictions ease, HT stated it is important that the Trust to start to develop these networks and have a plan of engagement. This will be taken forward in the development plan and PTIP. **The Board noted the Transaction Committee report.**
16.	**Future Service Transfers**
	SC stated that the two future transfers to take place are the children's services from BCH and community services from DGFT. In regards to the children's services, it has been agreed that the services will transfer in its entirety to the organisation. The process around agreeing service transfers with community services is underway currently, and a thorough risk assessment on each service is being undertaken by the Trust and DGFT using a QIA assessment tool. The QIA's plus an assessment by the CCG as the commissioner will be submitted to the Clinical Senate tomorrow in preparation for the panel meeting on 21st July. The output of that will be recommendations from the senate on the transfers of the services. SC reassured the Board that the clinical team have had engagement with some services at DGFT in the last few weeks. HT commented that it has been recognised by the Region the positivity of the two Trust Medical Directors and the momentum that is being achieved. It was highlighted that there have been a number of contacts from the community staff thanking the Executive Team for sharing information. **The Board noted the future service transfers update.**

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17.	**Board and Committee Effectiveness Review**
	EFD reported that following the effectiveness reviews, the updated Terms of Reference (ToR) have been recommended for approval and have been reviewed by the Board Committees. Primary Care Integration Committee will undertake a review of the ToR towards the end of quarter three following completion of its programme of Development Workshops. The Chair and Non-Executive Directors (NEDs) have completed the appraisal process and the 'fit and proper' person declarations. The Committee front sheets have been updated and EFD worked with the HR Team to ensure that these are EDI compliant and once taken through Executive Committee and presented at a Board Seminar, these will be used from September. It was noted that the Audit and Risk Committee self-assessment review took place at the meeting held on 24th May, the rating was strong. **The Board approve the Terms of Reference for Transaction and Transformation Committee and the Remuneration Committee**.
18.	**Report from Remuneration Committee**
	EFD reported that the committee welcomed and fully supported the recruitment of the Chief Operating Officer with immediate effect. This was submitted to NHSE/I and has been agreed. The Trust have now gone out to advert for this post and a lot of interest has been received. The Trust are looking at the end of August for the interviews with internal and external stakeholder panels. It was acknowledged that it is important to reach out and engage with the system on Executive appointments. **The Board noted the report from the Remuneration Committee.**
19.	**Use of Trust Seal**
	EFD reported that the Lease for Progress Point, the base for the School Nursing Service was signed by the Finance Director and Trust Secretary on 7 May 2021 and the common seal was applied. A quarterly report will be issued to the Audit and Risk committee to keep a record of use. **The Board noted the use of the Trust Seal.**
20.	**Audit and Risk**
	DG reported that the committee reviewed the report from the external auditor, and the committee used the delegated authority to approve the accounts, the annual report and annual governance statement. The timeframe for the auditor producing their value for money opinion has been revised this year due to the pandemic and auditors are not required to complete until 20th September 2021. However, the Trust's auditor has said that this piece of work should be completed by the end of July 2021 and EFD is canvassing dates for an extraordinary meeting to review this piece of work.

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	The Board noted the Audit and Risk Committee assurance report.
21.	**Any Other Business**
	None stated.
22.	**Questions from the public**
	No questions raised. HA had to leave the meeting slightly early but asked EFD to pass on a note of thank you for the openness, honesty and transparency throughout the meeting, and noted that it was great to see passion and enthusiasm about getting things right in Dudley.
23.	**Risk Reflection**
	No additional risks were raised following today's meeting.
24.	**Date of Next Meeting:**
	Wednesday 8 September 2021, 10.30 – 13.00

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Enclosure 1.5

DIHC Public Board Action Register

Dudley Integrated Health and Care NHS Trust

Ref	Date Raised	Details	Action Lead	Due Date	Update	Status
		No open actions				

Enclosure 3.2

Dudley Integrated Health and Care NHS Trust

DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

TITLE OF REPORT:	Chief Executive's Report
PURPOSE OF REPORT:	Board update on current issues
AUTHOR OF REPORT:	Paul Assinder, CEO
DATE OF MEETING:	8 September 2021
KEY POINTS:	1. Executive Recruitment 2. Health & Care Bill 2021 3. Devolution of Commissioning for Primary Care 4. Core 20 plus 5 Initiative
RECOMMENDATION:	The Board is asked to note the report.
ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:	No
ACTION REQUIRED:	Decision ☐
	Approval ☐
	Assurance ☒

Report of the Chief Executive to the Board of Directors

8th September 2021

1. Executive Recruitment Programme

The Trust has embarked upon a first phase of substantive recruitment to executive director roles – specifically Chief Operating Officer; Director of Nursing, Quality and AHPs; and Director of Strategy, Partnerships and People. At the time of writing, shortlisting had been completed for the Operations and Strategy and Partnerships posts and interviews were planned for week commencing 30th August.

A verbal update will be provided to the Board on the outcome of this process.

2. Health and Care Bill 2021

The Health and Care Bill has now had its second reading in Parliament and is scheduled to achieve its final reading early in the next parliamentary session. The changes proposed for the NHS will see the establishment of the following new bodies at Black Country Integrated Care System or ICS level:

The Black Country Health and Care Partnership Forum

Each ICS will have a partnership at system level established by the NHS and local government as equal partners. This will bring together NHS, local government and other partners to move forward with improving health and wellbeing. The ICS Partnership is expected to develop a System-wide 'Integrated Care Strategy' based on a Joint Strategic Needs Assessments. The Government does not intend to bring forward prescriptive legislation to say how partnerships should operate. The ICS NHS Body and local authorities must jointly select a Partnership Chair and define their role, term of office and accountabilities. The Black Country ICS is currently consulting with interested parties to shape such arrangements to take effect from April 2022.

The Black Country Integrated Care Board (ICB)

This new organisation will lead integration in the NHS, bringing together all those involved in planning and providing NHS services.
The Black Country Integrated Care Board will be a statutory organisation which will:

- Work with the Health and Care partnership Forum (described above) to develop a plan to meet the health care, social care, public health and population health needs of the population
- Allocate resources to deliver the plan, between different NHS organisations locally.
- Establish joint working arrangements
- Commission healthcare (potentially jointly with local authorities)
- Putting contacts and arrangements in place to secure delivery of its plan by providers
- Convening and supporting providers to lead major service transformation programmes
- Working with local authorities and Voluntary Community and Social Enterprise (VCSE) partners to put in place personalised care for people

- Establish governance arrangements - underpinned by statutory and contractual responsibilities to ensure the plan is delivered within the system financial envelope
- Lead system implementation of the **People Plan** supporting a 'one workforce' model
- Lead system-wide action on **data and digital** to put the citizen at the centre of their care
- Plan for, responding to and leading **recovery from incidents** (EPRR)
- Receiving the functions that NHS England and NHS Improvement will be delegating, including **commissioning of primary care and appropriate specialist services**.

It is expected Clinical Commissioning Group (CCG) functions, duties, assets and liabilities will transfer to an ICS NHS body. Statutory duties around children in care and special educational needs and disabilities (SEND) will apply to ICS ICBs as CCGs are abolished.

In addition to this intermediate tier at local 'place' level there will be the establishment of Health and Care partnership Boards.

The Dudley Integrated Care Partnership Board

At local 'place' level, the Dudley Health & Care Partnership (ICP) will operate. A 'shadow' Partnership Board has been in situ for over 12 months, made up of lead organisations in the NHS, local authority, primary care and voluntary sector and the Midlands and Lancashire CSU has been working with the Board for some months to develop a governance model that will accommodate its new role.

3. Devolution of commissioning for primary care services

This month, NHSEI provided an update on the proposed transfer of primary care functions from NHS England (NHSE) to the Integrated Care Board (ICB). Subject to the relevant legislation passing, the expectation is that from April 2022 ICBs will:

- Assume delegated responsibility for Primary Medical Services (currently delegated to all CCGs, and continuing to exclude Section 7A Public Health functions);
- Be able to take on delegated responsibility for Dental (Primary, Secondary and Community), General Optometry, and Pharmaceutical Services (including dispensing doctors and dispensing appliance contractors); and
- Establish mechanisms to strengthen joint working between NHSEI and ICSs, including through joint committees, across all areas of direct commissioning (in systems where they are not already delegated).

By April 2023, all ICBs will have:

- Taken on delegated responsibility for Dental (Primary, Secondary and Community), General Optometry, and Pharmaceutical Services;
- Taken on delegated commissioning responsibility for a proportion of specialised services (subject to system and service readiness) with national standards and access policies remaining at a national level;

- Worked collaboratively with NHSEI to determine whether some Section 7A Public Health services, and Health and Justice, Sexual Assault and Abuse Service commissioning functions will be delegated, with decisions on the appropriate model and timescale.

DIHC has held early discussions with the ICS Team to ensure that we are leading this initiative on behalf of the Dudley population.

4. Health Inequalities and Population Health – the Core20PLUS5 initiative

NHS England will shortly be launching a Health Inequalities Improvement Dashboard, which will give greater clarity on its five key planning priorities for 2022/23:

1. Supporting the health and wellbeing of staff and taking action on recruitment and retention
2. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
3. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
4. Expanding primary care capacity to improve access, local health outcomes and address health inequalities
5. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay

Next year's planning guidance reinforces the importance of working collaboratively across systems to deliver on these priorities.

In parallel, the **Core20PLUS5 initiative** will accelerate progress already achieved and target inequalities in clinical areas where unacceptable differences in life-expectancy remain:

- Core 20 – the most deprived 20% of our population
- PLUS – other population groups as identified by local population health data, eg ethnic minority communities
- 5 – targeting five key clinical areas of health inequalities:
- early cancer diagnosis
- identifying people with high blood pressure
- chronic respiratory disease
- annual health checks for people with serious mental illness
- continuity of maternity carer plans.

Clearly this initiative is absolutely consistent with our own direction of travel in DIHC and we will be working to align our own approach to addressing the very real inequalities of access in our own communities with the national approach.

PA Assinder

CEO

Enclosure 3.3

Dudley Integrated Health and Care NHS Trust

DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

WEDNESDAY 8 SEPTEMBER 2021
INSPIRATION 2, THE VILLAGE, DUDLEY, DY1 4TB
13.30 – 14.30

PRIVATE AGENDA

Item No	Agenda Item			Presented by	Time
1.	**Chair's Welcome**				13:30
	1.1 Apologies	To Receive	Verbal	Mr H Turner	
	1.2 Declarations of Interest	To Receive	Verbal	Mr H Turner	
	1.3 Private Board Minutes – meeting held on 6 July 2021	For Approval	Enc 1.3	Mr H Turner	
	1.4 Action Register and Matters Arising	For Approval	Enc 1.4	Mr H Turner	
	1.5 Items Carried Forward from Part One	For Discussion	Verbal	Mr H Turner	
3.	**Communications Update**	To Discuss	Verbal	Ms J Ilic/Ms H Codd	13:35
4.	**High Oak Surgery**	For Assurance	Enc 4	Mr P King	13:45
5.	**DIHC Development**				13:55
	5.1 Clinical Senate	For Discussion	Verbal	Mr R Bramble/Ms S Nicholls	
	5.2 Business Case Project Plan	For Assurance	Enc 5.2	Ms S Cartwright	
	5.3 Business Case Engagement Forum – Terms of Reference	For Information	Enc 5.3	Ms S Cartwright	
6.	**Ratified Committee Minutes**				14:15
	6.1 Quality and Safety Committee – meeting held on 15 June 2021	For Assurance	Enc 6.1	Ms V Little	
	6.2 Finance, Performance and Digital Committee – meeting held on 17 June 2021	For Assurance	Enc 6.2	Mr I Buckley	
	6.3 People Committee – meeting held on 22 June 2021	For Assurance	Enc 6.3	Mr M Evans	

Item No	Agenda Item			Presented by	Time
	6.4 Transaction Committee – meeting held on 8 June 2021	For Assurance	Enc 6.4	Ms S Cartwright	
	6.5 Primary Care Integration Committee – meeting held on 16 June 2021	For Assurance	Enc 6.5	Dr G Solomon	
7.	**Board Meeting Reflections**		Verbal	Mr H Turner	14:20
8.	**Any Other Business**		Verbal	Mr H Turner	14:25
9.	**Date of next meeting:** 5 October 2021, 12:30 – 13:30 Venue TBC				

Enclosure 5

Dudley Integrated Health and Care NHS Trust

DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

TITLE OF REPORT:	**Board Assurance Framework and Corporate Risk Register**
PURPOSE OF REPORT:	To receive the Board Assurance Framework and the Corporate Risk Register
AUTHOR OF REPORT:	Elaine Doyle, Trust Secretary
DATE OF MEETING:	8th September 2021
KEY POINTS:	The Board Assurance Framework (BAF) forms a part of the overall risk management and assurance process of the Trust and allows the Board to maintain oversight of the principal risks to delivery of the Trust's strategic objectives. All strategic and corporate risks are mapped to the Trust's strategic objectives and reporting of mitigations and actions are escalated through the relevant Trust Committee structures. A board seminar was held on 23rd August 2021 focussing on discussing the current system risks, board assurance strategic risks, corporate risks and project / transfer of services risks. Following consideration of the risk themes, we focused on the following areas for further focus in the next risk management review cycle: relationships, reputation, benefits and defining the risks from not addressing health inequalities for the population of Dudley. This work will the main focus of the quarterly BAF development. The BAF Tracker for August 2021, at Appendix 1, includes the latest risk rating, tolerance level and RAG rating of the assurances and controls and outstanding actions, it was last reviewed in full at the end of June, however, actions are updated monthly as part of the routine risk management cycle. The corporate risk register outlines current risks to the operational delivery of services and have been reviewed through the committees during July and August, with the following risk now escalated for inclusion on the corporate risk register. Appendix 2 details the Corporate Risks following a risk review by the Executive Directors and robust discussion at committees, there are no changes to scores for current corporate risks but the Board are asked to note that controls and actions have been updated to reflect the current position.

<table>
<tr><td></td><td>Following discussion at the August meeting of the Finance, Performance and Digital (F,P&D) committee, the Board are asked to approve the committee recommendation for the escalation of a new risk to the Corporate Risk Register.

The risk relates to the implementation of EMIS. For assurance a new data import iteration for the School Nursing Service has been now been completed and the data has been validated for import quality. Go-live is scheduled for 27th September with a contingency plan in place to support the go-live in advance of the legacy data transfer which has been supported by our partners Shropshire Community Health NHS Trust. This will ensure continued access to legacy data following go-live. The September F,P&D committee will receive a report from the Chief Information Officer, outlining the full assessment of the IT programme with supporting plan and will reflect all the ongoing work including the data input templates, reporting and a review of EMIS in response to the due diligence received for the transferring in services.

<table>
<tr><th colspan="3">Proposed New Corporate Risk</th></tr>
<tr><td>B-001 – EMIS Go-Live</td><td>High
16
(4 x 4)</td><td>Escalation of risk to corporate risk register</td></tr>
</table>

This paper provides:

• A summary of both the overall number and current score of risks contained in the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).

• The BAF Tracker is included at Appendix 1.

• A dashboard of the corporate operational risks is included on the BAF/CRR at Appendix 2.</td></tr>
<tr><td>RECOMMENDATION:</td><td>• Approve the new addition of the new risk updated scores and supporting mitigations</td></tr>
<tr><td>ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:</td><td>None identified</td></tr>
<tr><td rowspan="3">ACTION REQUIRED:</td><td>Decision ☐</td></tr>
<tr><td>Approval ☒</td></tr>
<tr><td>Assurance ☐</td></tr>
</table>

Board Assurance Framework and Corporate Risk Register

Risk Management Review Cycle and Changes

The Board Assurance Framework (BAF) details the strategic risks that could potentially impact on the delivery of the strategic objectives. The corporate risk register outlines current risks to the operational delivery of services and the potential impact of current and emerging issues such assessment of the impact of the ongoing Covid-19 pandemic.

A board seminar was held on 23rd August 2021 focussing on discussing the current system risks, board assurance strategic risks, corporate risks and project / transfer of services risks. Following consideration of the risk themes, we focused on the following areas for further focus in the next risk management review cycle: relationships, reputation, benefits and defining the risks from not addressing health inequalities for the population of Dudley. This work will the main focus of the quarterly BAF development.

During August 2021 the committees reviewed the mitigations, controls and supporting actions to address gaps in controls and assurances, and recommended no changes to the BAF and existing Corporate Risk Register scores.

Following discussion at the August meeting of the Finance, Performance and Digital (F,P&D) committee, the Board are asked to approve the committee recommendation for the escalation of a new risk to the Corporate Risk Register.

The risk relates to the implementation of EMIS. For assurance a new data import iteration for the School Nursing Service has been now been completed and the data has been validated for import quality. Go-live is scheduled for 27th September with a contingency plan in place to support the go-live in advance of the legacy data transfer which has been supported by our partners Shropshire Community Health NHS Trust. This will ensure continued access to legacy data following go-live. The September F,P&D committee will receive a report from the Chief Information Officer, outlining the full assessment of the IT programme with supporting plan and will reflect all the ongoing work including the data input templates, reporting and a review of EMIS in response to the due diligence received for the transferring in services.

Changes to the Corporate Risk Register as approved by Committees			
Finance, Performance and Digital 19th August 2021	B-001 – EMIS Go-Live	High 16 (4 x 4)	Escalation of risk to corporate risk register

BAF and Corporate Risk Register Summary Position

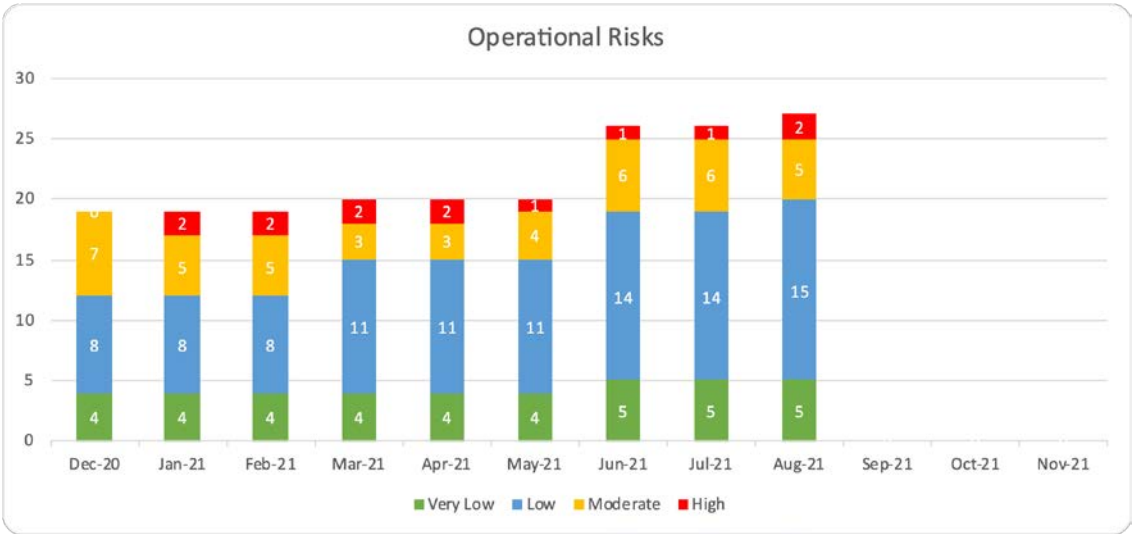
Appendix 1 details the full BAF Tracker Dashboard. The report shows clearly the current strategic risk rating, the tolerance level and the charts show the movement over time against within the tolerance levels defined for the strategic risk.

Below is a table showing the overall number and grade of risks and by domain held on the Board Assurance Framework and Corporate Risk Register, followed by a heat map of the eight strategic risks as recommended by the committees.

Risk Levels	1 Minimal	2 Cautious	3 Open	4 Seek	5 Mature
Risk Appetite	Very Low	Low	Moderate	High	
Risk Tolerance Score (Net L x C)	1 - 5	6 - 11	12 - 15	16 - 25	
No of BAF Risks	**1**	**2**	**3**	**2**	
No of Corporate Risks	**5**	**14**	**6**	**1**	

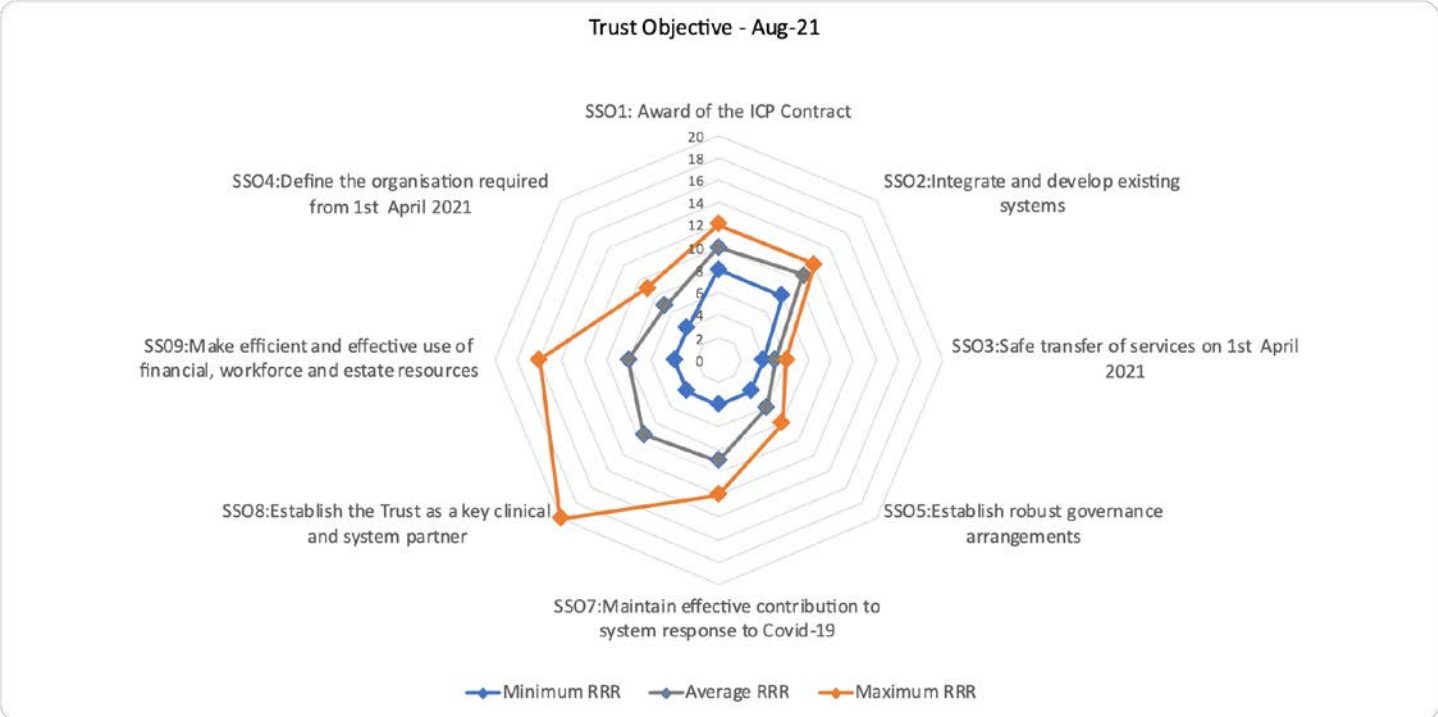
Heat Map of BAF Current Score						
		CONSEQUENCE				
		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
LIKELIHOOD	1. Rare	1	2	3	4	5
	2. Unlikely	2	4 002	6	8	10
	3. Possible	3	6	9 003, 008	12	15
	4. Likely	4	8	12 004, 005, 006	16 001, 007	20
	5. Almost Certain	5	10	20	20	25

Below is the total number of corporate risks since over time by current score. Please note that during January the Corporate Risk Register was aligned to the BAF and Risk Management Strategy risk assessment matrix as outlined in the section 1 above.



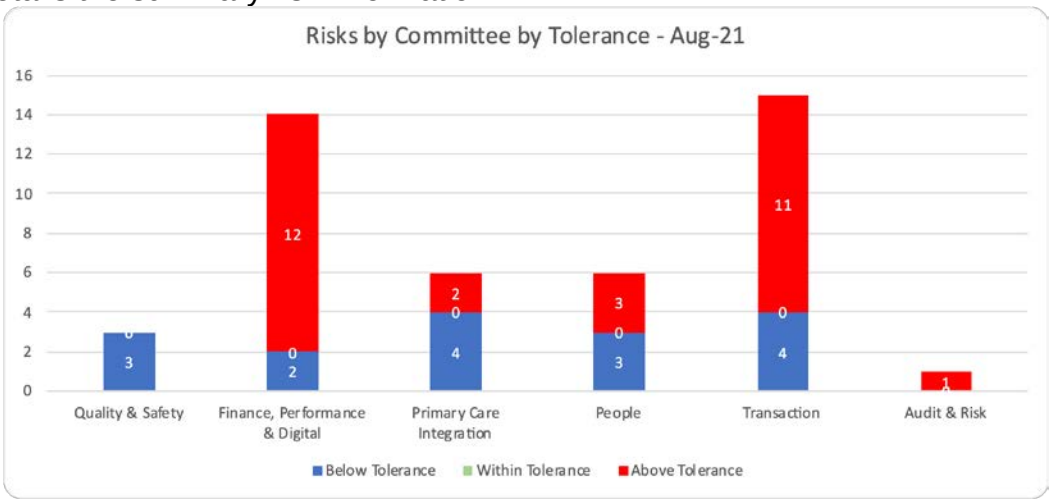
The spider diagram below shows the average current risk score mapped to the strategic objectives. Where the lines are closer together this shows the risk portfolio of the strategic objective has a narrower margin of tolerance. The further apart the lines the wider the margin of tolerance.

The use of the colour (orange, grey and blue) follows the Trust's Business Intelligence and Key Performance Reports and follows NHSEI guidance on Making Data Count and best practice in supporting Accessible Information Standard. The colours are based on research and evidence to aide understanding of data, with orange used to depict maximum tolerance or negative, grey for current position or neutral and blue as minimum tolerance or positive.



The risk appetite domain category, with the lowest tolerance, is Safety encompassing Statutory and Regulatory Compliance, which is defined as risks relating to the impact of Covid-19 and the safe landing and integration of services following transfer. From the spider diagram, the average risk rating of the portfolio of risks relating to this domain are within tolerance.

The chart below outlines the current profile of risks by committee by tolerance. The trend reports at Appendix 2 details the summary risk information.



A table of assurance strengths by strategic risk and a summary table of the volume of controls is below.

Summary of Aggregated BAF Risks by Assurances and Actions					
Effective Control - Assurance Strengths			*Actions - Progress*		
	Nos	*%*		*Nos*	*%*
Strong	21	47	Completed	19	91
High	19	42	Green	2	9
Medium	5	11	Amber	0	0
Low	0	0	Red	0	0
Totals	45	100	Totals	22	100

1. Next Steps

The risk management report will continued to be updated to show the movement in risk scores, assurance (controls and mitigations) and actions including the amendments to risk, alignment of the BAF with the Corporate Risks, escalation of risks, risks marked for de-escalation and information on emerging risks and horizon scanning.

During September and October 2021 the committees will approve the refreshed BAF and strategic risks. Detailed plans for the importing of the BAF and corporate risk registers into the Risk Management Module of Datix is being developed. A comprehensive training and awareness plan will be developed and reported to Executives for sign off during September 2021.

Appendix 1

Board Assurance Framework (BAF)

PUBLIC BOARD

SEPTEMBER 2021

Appendix 1

BAF TRACKER DASHBOARD FOR ALL STRATEGIC RISKS

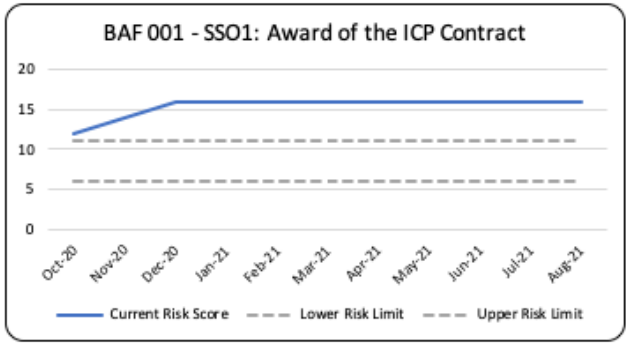
Strategic Priorities	BAF Risk No	Risk Descriptor	Exec Lead	Risk Oversight Committee	Inherent Risk Score October 2020 (LXC)	Risk Score Q3 December 2020 inc Movement	Risk Score Q4 March 2021 Inc Movement	Risk Score Q1 June 2021 Inc Movement	Risk Appetite Domain	Risk Toler-ance Level	Assurance on Controls	Actions on Track
SSO1: Award of the ICP contract	BAF-001	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	Steph Cartwright, Director of Operations, Strategy and Partnerships	Transaction & Transformation	Moderate12 (4x3)	High 16 (4x4)	High 16 (4x4)	High 16 (4x4)	System Partnerships	Low 6 to 11	Medium	Green
SSO2: Integrate and develop existing services	BAF-002	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	Matt Gamage, Director of Finance, Performance and Digital	Finance, Performance & Digital	High 16 (4x4)	Very Low4 (2x2)	Very Low 4 (2x2)	Very Low 4 (2x2)	Sustainability (Resources)	Low 6 to 11	Medium	Green

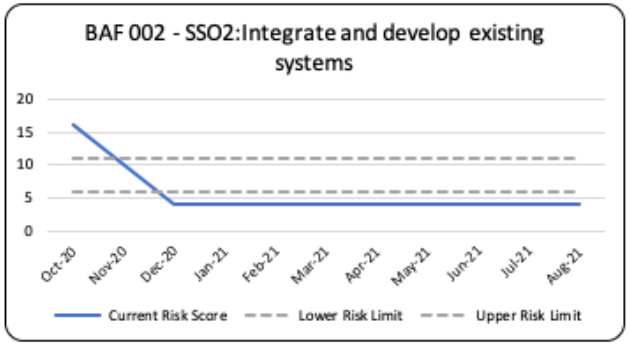
		partnership working										
SSO3: Safe transfer of services on 1st April 2021	BAF-003	There is a risk that there are insufficient resources and systems in place to safely and effectively manage the transfer of additional services into the organisation	Steph Cartwright, Director of Operations, Strategy and Partnerships	Transaction	Low 9 (3x3)	Low 9 (3x3)	Low 9 (3x3)	Low 9 (3x3)	**Safety** Sustainability (Resources) Infrastructure	Very Low 5 and below	Medium	Green
SSO5: Establish robust governance arrangements	BAF-004	There is a risk 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		Quality & Safety	Moderate12 (4x3)	Moderate12 (4x3)	Moderate12 (4x3)	Moderate12 (4x3)	**Safety** Quality Reputational	Very Low 5 and below	High	Green

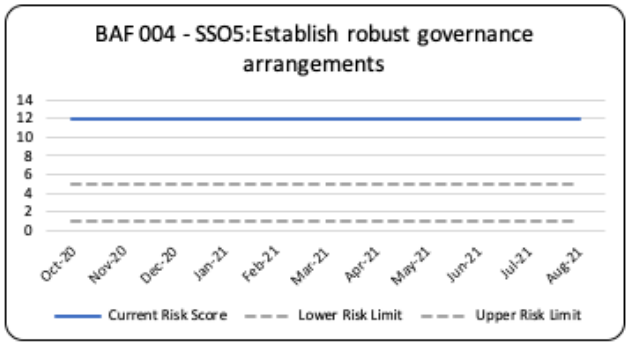
		potentially could impact on patient safety										
SSO7: Maintain effective contribution to system response to Covid-19	BAF-005	There is a risk that the Trust unable to meet demand in relation to the COVID-19 response	Caroline Brunt, Director of Nursing, AHPs and Quality	Quality & Safety	Moderate12 (4x3)	Moderate12 (4x3)	Moderate12 (4x3)	Moderate12 (4x3)	**Safety** Quality Reputational	Very Low 5 and below	High	Green
SSO8: Establish the Trust as a key clinical and system partner	BAF-006	There is a risk that the Trust is unable to effectively engage with its system partners and demonstrate appropriate system leadership	Steph Cartwright, Director of Operations, Strategy and Partnerships	Transaction	Moderate12 (4x3)	Moderate12 (4x3)	Moderate 12 (4x3)	Moderate12 (4x3)	**Reputational** Collaboration	Low 6 to 11	High	Green
SS09 - Make efficient and effective use of financial, workforce and estate resources	BAF-007	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	Matt Gamage, Director of Finance, Performance and Digital	Finance, Performance & Digital	Moderate12 (4x3)	High 16 (4x4)	High 16 (4x4)	High 16 (4x4)	Sustainability (Resources)	Low 6 to 11	High	Green

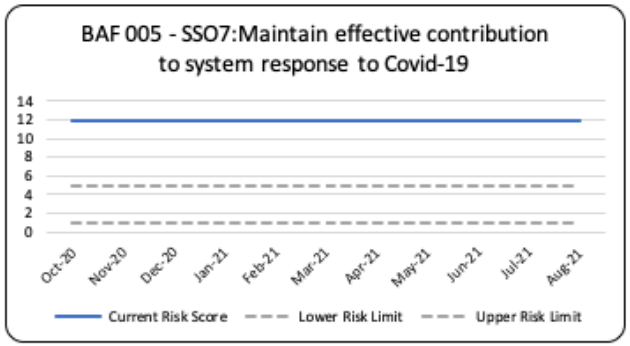
SSO4: Define the organisation required from 1st April 2021	BAF-008	There is a risk DIHC can't recruit, train and retain the appropriate innovative workforce required to deliver the transformational Integrated Care Provider ambitions for service users	Bev Edgar, Director of People	People	Low 9 (3x3)	Low 9 (3x3)	Low 9 (3x3)	Low 9 (3x3)	Workforce	Low 6 to 11	High	Green

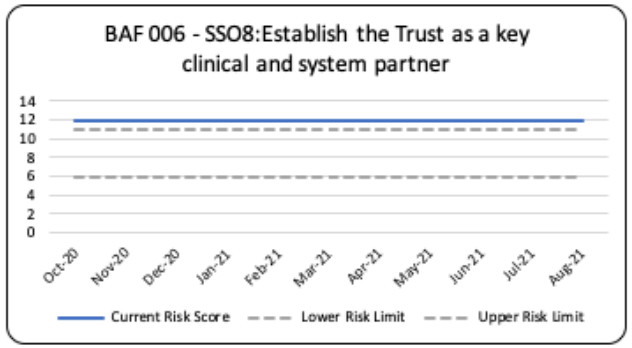
Board Assurance Framework

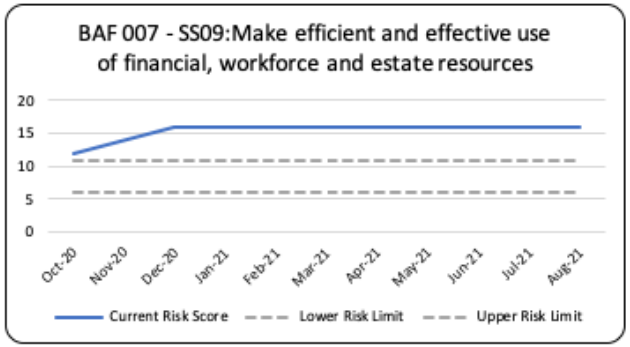


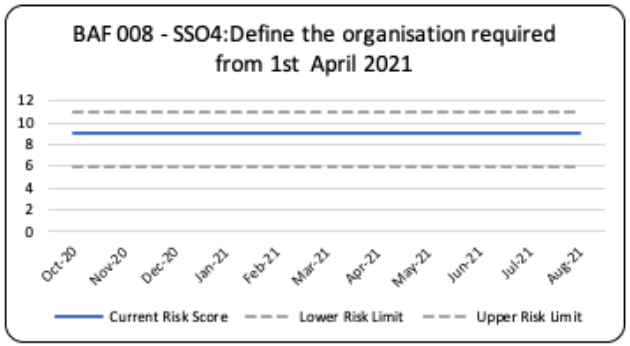












Corporate Risk Register Dashboard and Trend Report

Latest Month

Ref	Domain	Committee	Accountable Director (Risk Sponsor)	RISK OF:	Monthly Risk Score Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Movement	Trend	Above or Below Tolerance
C-106	Safety	Transaction	Steph Cartwright	Not having approval from NHSEI to recruit substantively to key posts prior to April 1st 2021	16	16	16	16	12	12	12	8	↑		Above
C-107	Partnerships	Transaction	Steph Cartwright	Insufficient system-wide support for the creation of the ICP	12	12	12	12	8	12	12	12	→		Above
C-064	Workforce	People	Bev Edgar	Risk of substantive workforce shortages (through vacancies, absence or excess demand) result in additional premium costs being incurred.	16	16	16	16	16	16	16	16	→		Above
C-067	Sustainability	F, P & D	Matt Gamage	Risk of sub-contract terms and incentives not aligned with ICP contract or strategy	12	12	12	12	12	12	12	12	→		Above
C-070	Sustainability	F, P & D	Matt Gamage	Risk of increase in drug volume and prices in excess of planned growth and inflation	12	12	9	9	9	9	9	9	→		Above
C-073	Sustainability	F, P & D	Matt Gamage	Risk of placement costs relating to Continuing Health Care to be in excess of planned levels due to any unforeseen changes to the eligibility criteria and sufficiently robust system to record costs accurately	12	12	9	9	9	9	9	9	→		Below
C-102	Partnerships	Transaction	Steph Cartwright	Risk of lack of system alignment	12	12	12	12	8	12	12	12	→		Above
C-030	Workforce	Transaction	Bev Edgar	Risk of significant vacancy factors in staff groups that transfer into the ICP due to the workforce becoming unsettled around the new model of care or organisational change	12	12	12	12	12	12	12	12	→		Above
C-078	Quality	Transaction	Matt Gamage	Risk of delayed implementation of clinical service strategy as organisation is established	12	12	12	12	12	12	12	12	→		Above
C-101	Workforce	People	Steph Cartwright	Risk of COVID-19 affecting staff	12	12	12	12	12	12	12	12	→		Below
C-103	Sustainability	Transaction	Steph Cartwright	Lack of sufficient resources being available to support safe landing due to delays incurred as a result of COVID-19	12	12	12	12	12	12	12	12	→		Above
C-105	Sustainability	Transaction	Steph Cartwright	Increased pressure of Covid management during winter reduces NHSE/I capacity to review full business case in the agreed timescales	8	8	8	8	8	8	8	8	→		Above
C-024	Safety	F, P & D	Matt Gamage	Risk of not being able to appropriately share patient information across the ICP partners and its stakeholders due to data sharing agreements may not be in place	10	10	8	8	8	8	8	8	→		Above
C-023	Infrastructure	F, P & D	Matt Gamage	Risk to the delivery of ICP due to digital strategy not clearly defined	9	9	9	9	9	9	9	9	→		Above
C-057	Sustainability	F, P & D	Matt Gamage	Risk of reduction in annual payments due to factors beyond the control of the ICP	9	9	9	9	9	9	9	9	→		Above
C-076	Sustainability	F, P & D	Matt Gamage	Risk of restricted access to investment funds due to other financial pressures	9	9	9	9	9	9	9	9	→		Above
C-060	Sustainability	F, P & D	Matt Gamage	Risk of planned efficiencies and benefits not delivered in full due to restricted investment, following the formation of the ICP	9	9	9	9	9	9	9	9	→		Above
T-033	Commercial	Transaction	Matt Gamage	Negotiation of terms with supply chain organisations not finalised	8	8	8	8	8	8	8	8	→		Above
C-051	Sustainability	F, P & D	Matt Gamage	Risk of ICP failing to attract appropriate income under the payment by outcomes arrrangements	8	8	8	8	8	8	8	8	→		Above
C-053	Sustainability	F, P & D	Matt Gamage	Risk of cash not being received on a timely basis, leading to ICP cash shortfall	8	8	6	6	6	6	6	6	→		Above
C-063	Sustainability	F, P & D	Matt Gamage	Risk of financial overspend due to insufficient financial controls which may result in unauthorised over spend, loss of financial control inability to meet the control total and impact on service delivery	8	8	8	8	8	8	8	8	→		Above
T-047	Reputational	Transaction	Steph Cartwright	Failure to engage and communicate with patients, staff and the public on ICP mobilisation and developments for the changes to existing service and models for new services in Dudley	8	8	8	8	8	8	8	8	→		Above
C-084	Quality	Transaction	Steph Cartwright	Risk of uncoordinated care delivered to the population by various service providers and patient access points, due to clinicians unwilling to change practices	6	6	6	6	6	6	6	6	→		Below
C-031	Sustainability	F, P & D	Matt Gamage	Risk of contract financial envelope less than the cost of providing the services	6	6	6	6	6	6	6	6	→		Above
C-088	Infrastructure	Transaction	Matt Gamage	Risk to the health care estates function of the ICP due to nsufficient capital funding available to make necessary premises investments, as the ICP will have limited capital funding of its own, and access to PFI and national capital is limited and insufficient space within the community healthcare estate to fully implement the ICP clinical model in each locality	6	6	6	6	6	6	6	6	→		Above
C-104	Reputational	Audit and Risk	Paul Assinder	Risk of legal action as a result of decisions made in response to COVID-19	4	4	4	4	4	4	4	4	→		Above
C-046	Quality	Transaction	Bev Edgar	Risk of failure to identify and manage cultural differences between organisations coming together in ICP and as a result causes	6	6	6	6	6	6	6	6	→		Above
C-082	Safety	Q&S	Steph Cartwright	Risk to the continuity of business due to not fully formed and robust business continuity plans	4	4	4	4	4	4	4	4	→		Below
T-037	Workforce	Transaction	Bev Edgar	Risk of delay/protracted HR consultation periods and risk of delay resulting from any Trade Union disputes	4	4	4	4	4	4	4	4	→		Below
T-045	Infrastructure	Transaction	Steph Cartwright	Risk of occupation/lease agreements for required premises are not in place by contract start date. There is a Lack of clarity around responsibilities and costs - potential delay in contract start	4	4	4	4	4	4	4	4	→		Below
T-085	Reputational	Transaction	Bev Edgar	Risk to reputation and delayed implementation of workforce support due to lack of communication provision and visibility of the leadership	4	4	4	4	4	4	4	4	→		Below
C-108	Quality	Q&S	Chris Weiner	There is a risk that EU Exit disrupts the supply chain of goods, services or people required by the Trust to deliver its clinical services	4	4	4	4	4	4	4	4	→		Below
C-032	Sustainability	F, P & D	Matt Gamage	Risk of finance function is unable to discharge its duties following the ending of provision of support from BCH	0	0	8	8	8	4	4	4	→		Below
C-201	Sustainability	PCI	Steph Cartwright	Risk of DIHC not being in alignment with PC and not maintaining PC at the heart of its strategic direction, future planning and engagement plans	0	0	0	0	0	6	6	6	→		Below
C-202	Reputational	PCI	Matt Gamage	Lack of business intelligence information to target ICTs to support PCNs and links to ICS / CCG (F,P&D)	0	0	0	0	0	8	8	8	→		Below
C-203	Partnerships	PCI	Steph Cartwright	DIHC failure to develop an acceptable full integration strategy and agreement	0	0	0	0	0	6	6	6	→		Below
C-204	Innovation	PCI	Richard Bramble / Lucy Martin	Failure to develop a primary care operating model at scale and in part is dependant on transfer of community services	0	0	0	0	0	12	12	12	→		Above
C-205	Reputational	PCI	Steph Cartwright	Lack of infrastructure for ARRS staff including IT, accommodation, supervision and management especially HR support over next 6 to 12 months	0	0	0	0	0	6	6	6	→		Below
C-206	Reputational	PCI	Richard Bramble / Lucy Martin	Lack of progress on the development of the Prescription Ordering Service (POD)	0	0	0	0	0	12	12	12	→		Above

Enclosure 6

Dudley Integrated Health and Care NHS Trust

DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

TITLE OF REPORT:	Medical Directors' Report for Board
PURPOSE OF REPORT:	To update the Board on the Medical Directorate's activity
AUTHOR OF REPORT:	Dr Richard Bramble & Dr Lucy Martin, Acting Joint Medical Directors
DATE OF MEETING:	8 September 2021
KEY POINTS:	1. Health Inequalities - These have been at the forefront of all of our discussions. Data is available now to show the disadvantages faced by so many different groups of the residents of Dudley have been made worse by COVID-19. It is a key area of concern, and all work done by the Medical Directorate will have this data in mind. 2. PCN CDs - very positive relationships continue with our CDs, via PCIC and attendance at their meeting monthly. Planned away day between DIHC, PCN CDs and Dudley place CCG to work on clinical strategy and direction on September 16th. CDs are providing vital strategic insight for DIHC. 3. GP practice engagement - this continues on multiple levels: joint events with DGFT clinicians will return to monthly from September, clinical forum monthly between clinical leads from DIHC / CCG, GP education events every two months with all practices invited and protected time provided, individual practice engagement sessions with MDs and Head of Primary Care. Practices are coming to DIHC for support with particular issues, indicating their commitment to partial integration. 4. Medical leadership team - Dr Mark Hopkin has retired from DIHC and finished working with us on 31st July 2021. He has provided many years of his time and expertise on respiratory problems and we thank him for his immense contribution to improving patient care and relationships with our partners over the years. We wish him all the best for a happy retirement.

	5. Medical team restructure - the new proposed medical leadership structure has now been agreed at Executive level. This takes into account the governance and corporate structures that will need to be in place for any future service transfers. With support from the People Team we are now developing new job role descriptions and will be entering into a 30 day consultation period with our existing medical team from the end of September. 6. The largest piece of work since our last public board meeting was our preparation for presentation to the Clinical Senate at the end of July and the subsequent work on development of the six clinical pathways the Senate require for our next review on 13th September. An incredible amount of work has been done by our clinical leads and their counterparts in our Partner Organisations to clarify the clinical pathways development that has gone on to date, and for DIHC to express the vision for the future pathways to transform care for Dudley patients. Lots of work has gone in to building our relationships with our partners through this process and we look forward to working with system partners to progress further. 7. Within the pharmacy team a new appointment has been made for the role of lead pharmacist for PCNs. This will be another key role in ensuring the integration of primary care with DIHC.
RECOMMENDATION:	The Board accepts this report for assurance of Medical Directorate activity.
ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:	Medical Directors and PCN Clinical Directors have similar financial and professional interests in their own practices and as shareholders of Future Proof Health.
ACTION REQUIRED:	Decision ☐
	Approval ☐
	Assurance ☒

Enclosure 7

Dudley Integrated Health and Care NHS Trust

Quality & Safety Report

Reporting period: June & July 2021

Reporting to: August 2021 Quality & Safety Committee

Reported by: Caroline Brunt, Director of Nursing, Quality & AHPs
Jim Young, Head of Quality & Governance

Summary

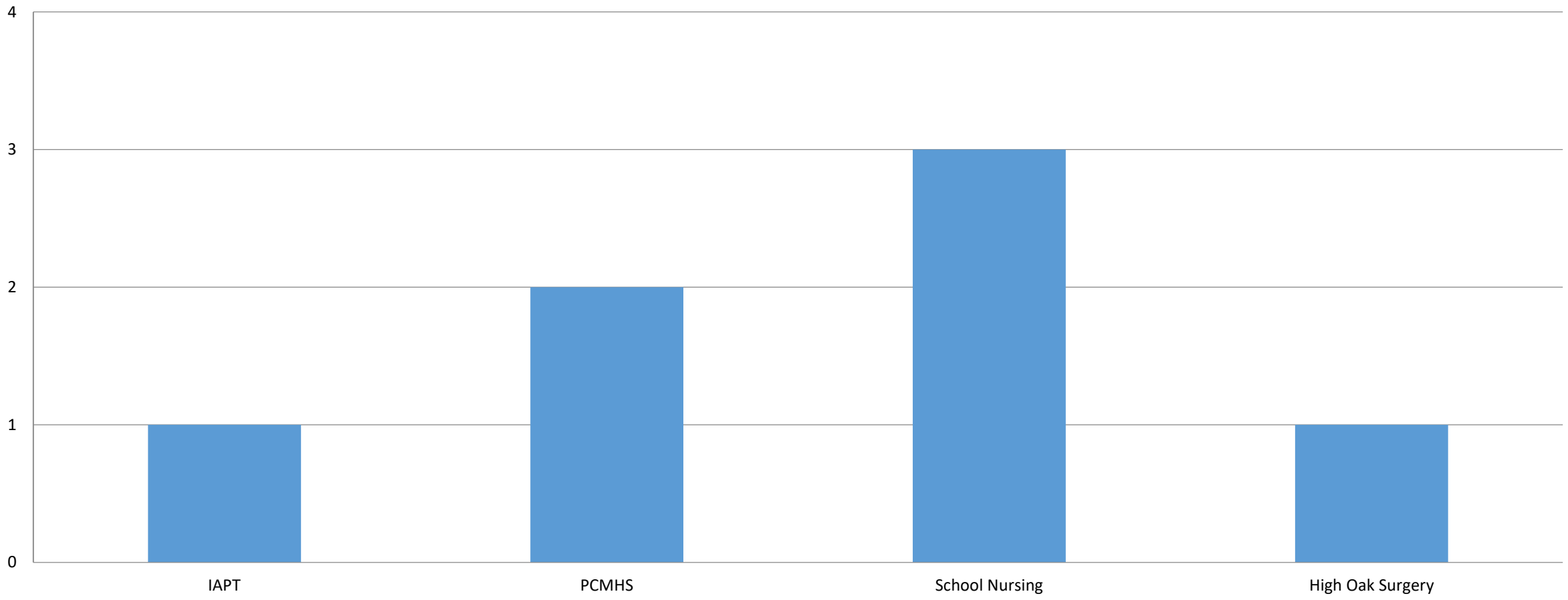
Data / Quality Indicators	Other
• No Serious Incidents reported in June or July • Numbers of incidents have increased in July from previous months – these appear to be as a result of 'one-off' system issues but will continue to be monitored • Six formal complaints reported this period	

Recommendations

- Based on the quality indicator data currently available, together with the area-specific narrative relating to key areas of quality & safety there do not appear to be any concerns regarding the quality of services currently provided by the Trust
- Based on the quality indicator data currently available there do not appear to be any concerns with regards to emerging trends; this assurance will be improved by the development of appropriate statistical analysis over time
- **There are no issues or concerns requiring escalation to the Board**

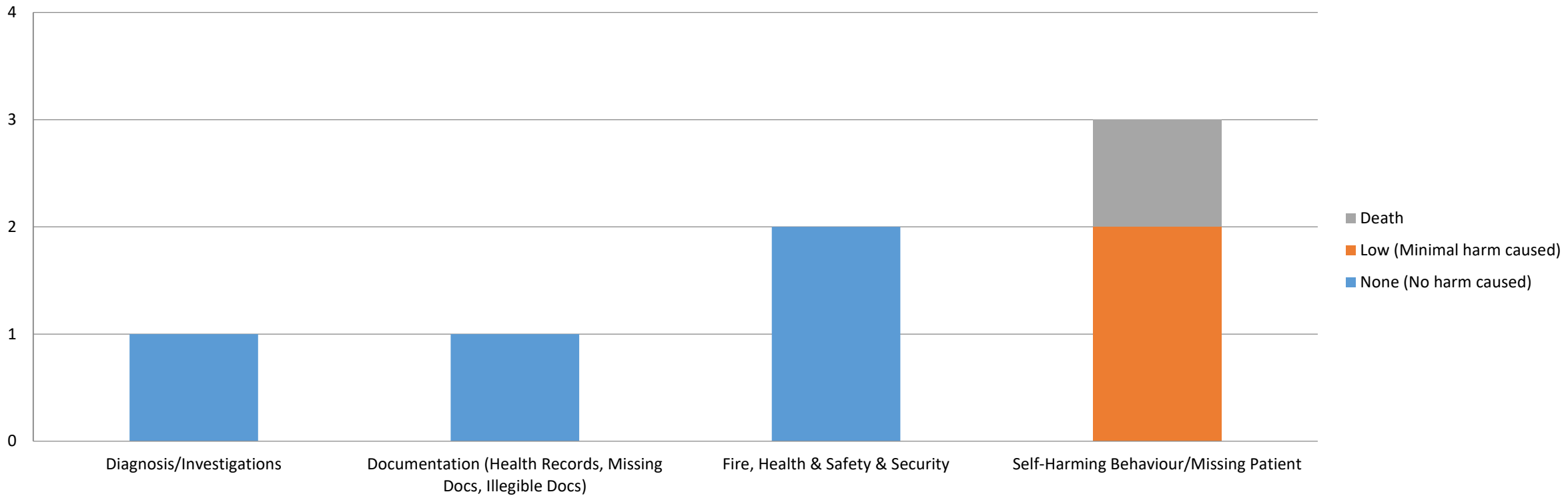
INCIDENTS

INCIDENTS - reported during June 2021 (by service)



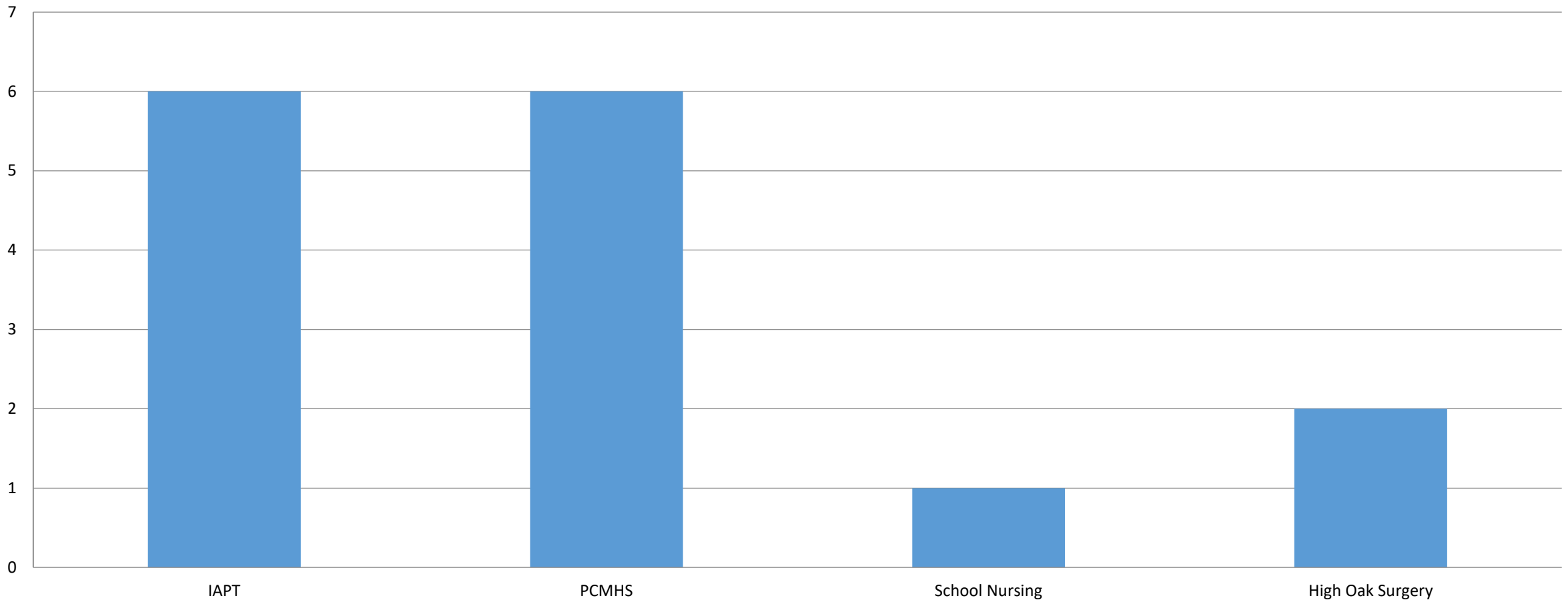
- 7 incidents reported this month; none meet the criteria for reporting as an SI

INCIDENTS - reported during June 2021 (by category / severity)



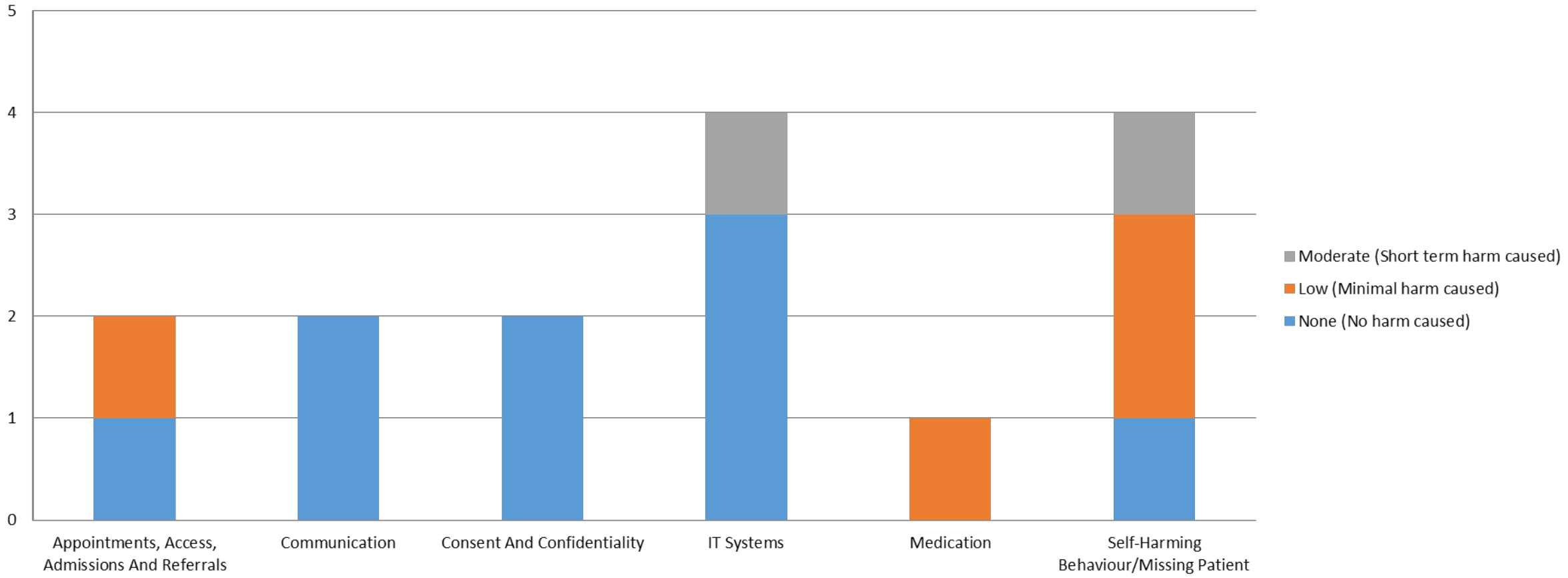
- No immediate issues or themes identified
- One incident relates to the death of an individual – at the time they were under the care of another Trust who have reported this as their SI; the individual had recent contact with both DIHC PCMHS and IAP services and DIHC will be contributing to the investigation as required.
- The two H&S incidents relate to the School nursing team and were quickly reviewed by the H&S lead and appropriate actions identified

INCIDENTS - reported during July 2021 (by service)



- 15 incidents reported this month; none meet the criteria for reporting as an SI
- This only appears to represent a significant increase on previous months due to the numbers being relatively low
- Approximately half of the incidents relating to the mental health services relate to minor issues with IT / IG systems; these appear to be one-off issues but will continue to be monitored

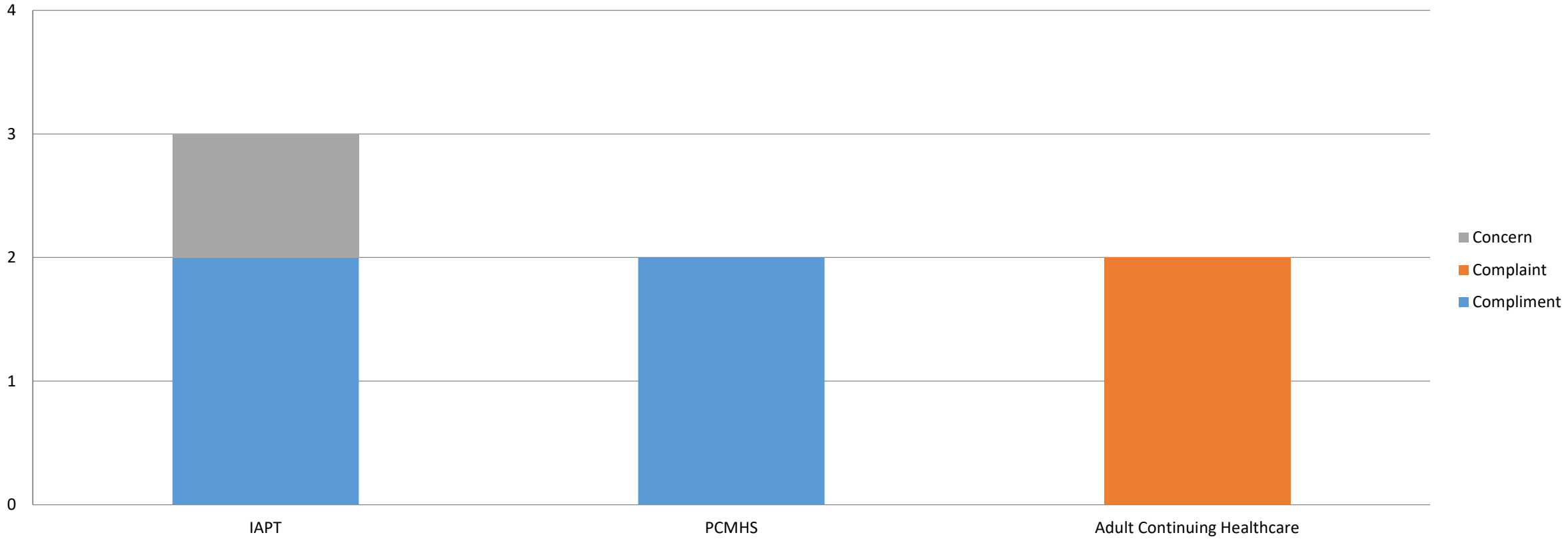
INCIDENTS - reported during July 2021 (by category / severity)



- No immediate issues or themes identified; a number of IT / IG system-related incidents which appear to be one-off issues but will be monitored
- Self-harm incidents continue to be monitored
-

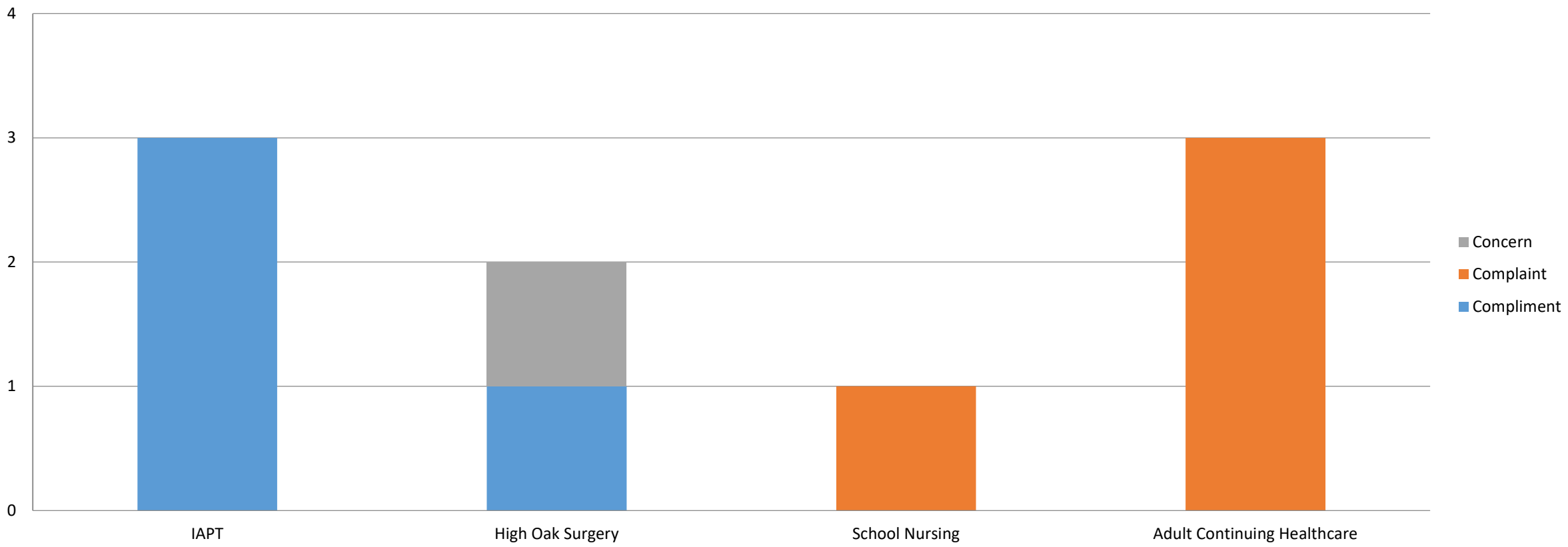
SERVICE USER FEEDBACK

SERVICE USER FEEDBACK – reported during June 2021 (by service / type)



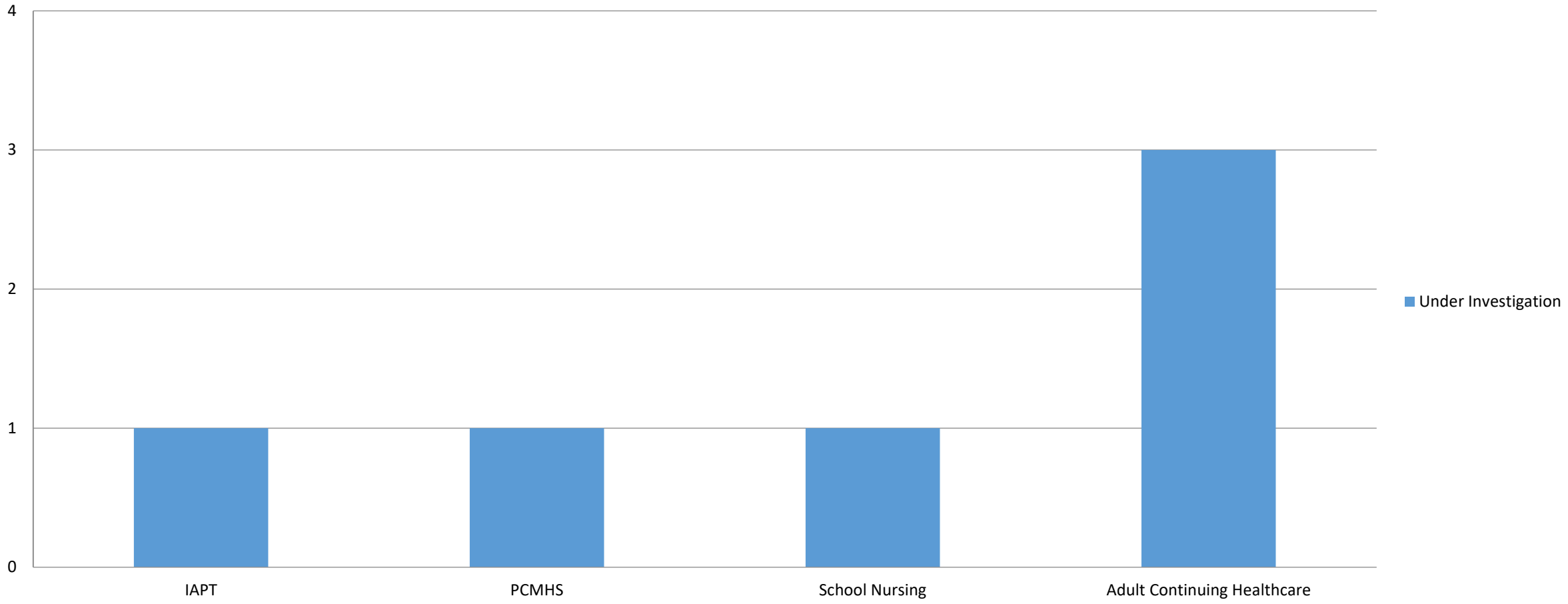
- A total of seven pieces of feedback have been received this month
- The two complaints relate to CHC, received via the CCG; responses have been produced for both of these
- The compliments for both PCMHS and IAPT relate to the support shown by staff for patients and the quality of care provided

SERVICE USER FEEDBACK – reported during July 2021 (by service / type)



- A total of nine pieces of feedback have been received this month
- Of the three CHC complaints, one relates to a funding decision and the other is one part of a wider complaint being managed by another Trust
- The three compliments for IAPT relate to the support providing by staff, including specific mention of individual

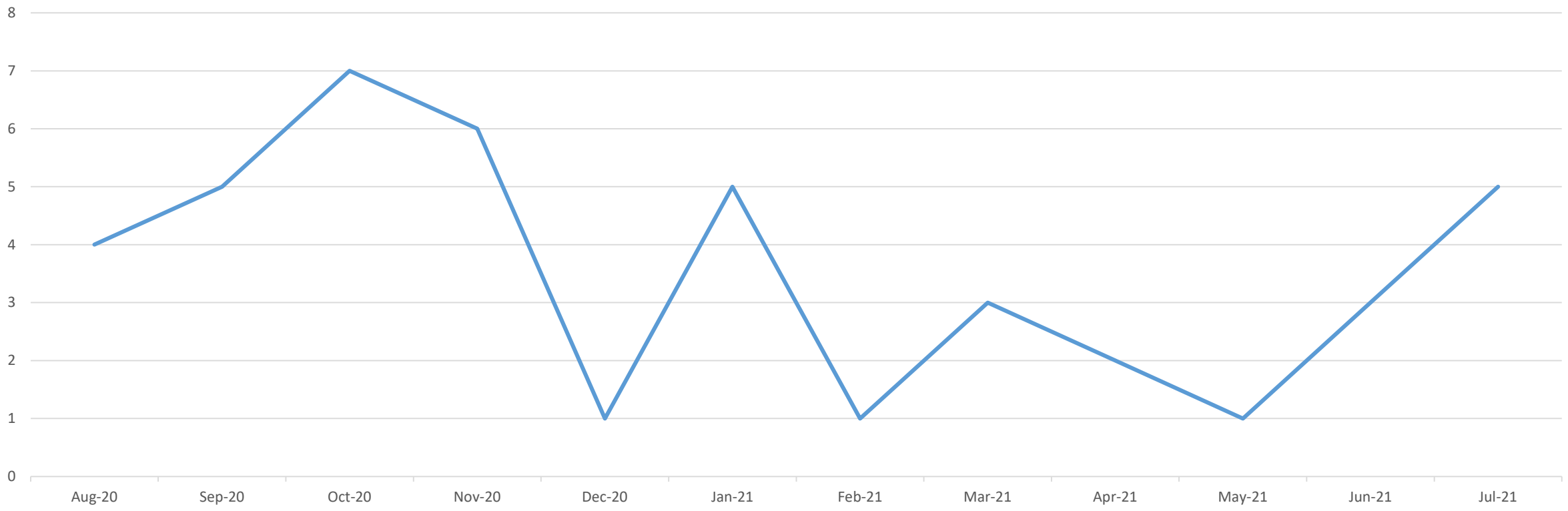
SERVICE USER FEEDBACK – open complaints (by service / current stage)



- There have been some difficulties in getting in touch with the two mental health service complainants, but these are now nearing completion

SERVICE USER FEEDBACK – complaints / concerns

Complaints / concerns – rolling 12 months



- There are no obvious trends or concerns emerging from the 12 month rolling dataset; numbers increased over the past two months so will continue to be monitored

SERVICE USER FEEDBACK – Friends & Family Test (FFT)

- Currently only reporting FFT data for High Oak; appropriate reporting currently being developed for other services
- Latest data for High Oak shows a continued level of positive responses:

Month	Total no. of respondents	% not recommended	% neither / don't know	% recommended
Jan 21	71	4.2%	1.4%	94.4%
Feb 21	59	0%	0%	100%
Mar 21	43	2.3%	2.3%	95.4%
Apr 21	35	3%	3%	94%
May 21	53	4%	2%	94%
Jun 21	51	6%	0%	94%
Jul 21	55	4%	4%	93%

SAFEGUARDING

SAFEGUARDING - update

- There are no escalations to report to Q and S. An update on progress is detailed below
- Domestic Abuse guidance for managers and staff has been ratified and uploaded onto the DIHC intranet
- Safeguarding Supervision sessions are being undertaken with focussed support to the PCMH and IAPT teams in accordance with the Trusts safeguarding supervision policy
- Monitoring of training compliance continues and is reported through to the people committee. Poor compliance is escalated via executive leads
- A suite of 7 minute briefings have been developed and are available on the intranet. These are also disseminated to all staff via Friday Round Up
- The CHC team have commissioned support to undertake CDOLs assessments and work progresses to prepare for the introduction of Liberty Protection Safeguards
- The Trust is in the recruitment phases for an Adult safeguarding MASH nurse and a Named Nurse for Adults Safeguarding
- A safeguarding work-stream has been agreed aligned to the transfer planning process for Black Country Healthcare.

INFECTION PREVENTION & CONTROL

INFECTION PREVENTION & CONTROL - update

- There are no escalations to report to committee
- The Trust is in the recruitment phases for an IPC specialist practitioner
- The Trust communicates IPC updates to all staff - this has recently included;
  - Process regarding exemptions from self-isolation
  - Process / advices for patients who refuse/are unable to wear masks in clinical areas
- IPC advice has been provided to the office redesign and return to the office work-streams
- The Trust is currently planning the 21/22 staff flu campaign; this work-stream is overseen by the People Committee
- At the time of writing the report the final guidance relating to vaccination of people working or deployed in care homes has been released; this is currently being reviewed by the Trust for a considered action plan as appropriate

COVID VACCINATIONS – Patients (High Oak)

- Covid vaccination programme at High Oak continues; latest uptake data (as of 03/08/2021):

Age group	Total Population Per Cohort	Total Vaccinated FIRST DOSE (%)	Total Vaccinated SECOND DOSE (%)	Total patients declined
COHORT ONE CARE HOME	6	100%	83%	0
COHORT TWO 80+	194	96%	95%	6
COHORT THREE +75	106	94%	92%	2
COHORT FOUR 70+	350	93%	91%	8
COHORT FIVE 65+	128	93%	91%	3
COHORT SIX 16-64 UHC ANY AGE	466	83%	79%	7
COHORT SEVEN 60-64 OR UHC	88	92%	91%	2
COHORT EIGHT 55+	136	92%	86%	3
COHORT NINE 50+	170	81%	77%	4

COVID VACCINATIONS – Staff

- Covid vaccinations uptake continues to increase for both patient and non-patient facing staff
- Latest uptake data now includes details of 1st and 2nd doses (as of 09/08/2021):

COVID-19	First dose % vaccinated	Second dose % vaccinated
Patient facing	89%	85%
Non-patient facing	100%	94%
Organisation	90%	86%

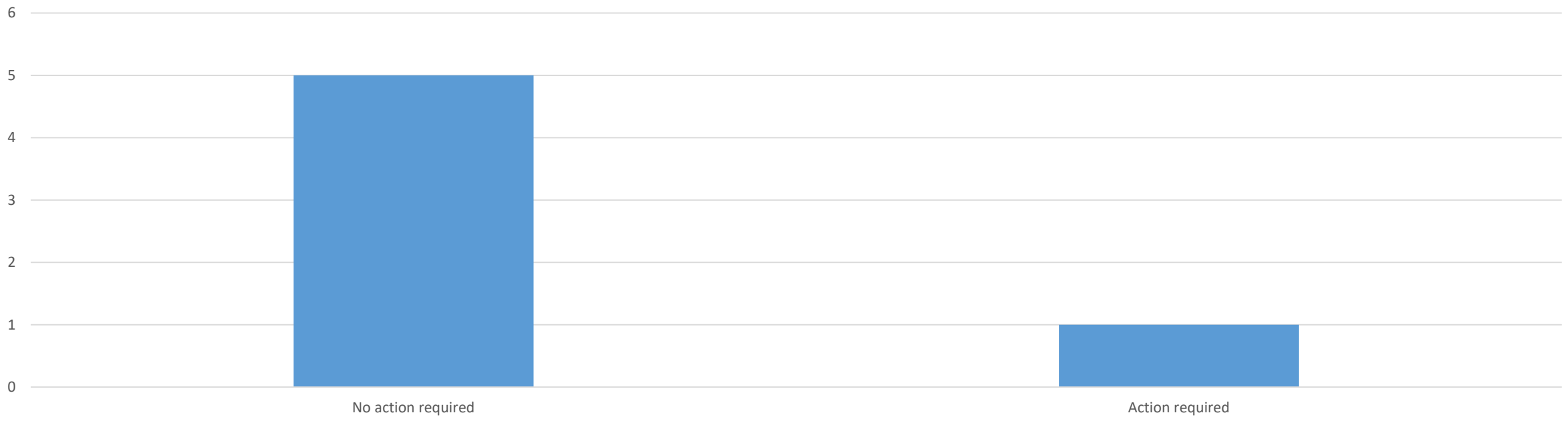
- Further workforce information will be provided and discussed at the People Committee

SAFETY ALERTS

CAS / SAFETY ALERTS – reported during June 2021

- 7 alerts have been reported this month; no actions required
- There are no alerts with any outstanding actions

CAS / SAFETY ALERTS – reported during July 2021



- 6 alerts have been reported this month; one required action which has been completed within the required timeframe
- There are no alerts with any outstanding actions
- The Datix safety alert module is currently being implemented

HEALTH & SAFETY

HEALTH & SAFETY

- No specific issues or concerns identified; a number of H&S-related incidents have been reported and acted upon accordingly
- Support continues to be provided by Black Country Healthcare NHS FT via an SLA; this includes a current focus on reviewing and updating risk assessments

Enclosure 8

Dudley Integrated Health and Care NHS Trust

COMMITTEE ASSURANCE REPORT TO THE BOARD

Committee: **Quality & Safety Committee**

Date of meeting: 17th August 2021 (via Microsoft Teams)

Presented by: Valerie Little, Non-Executive Director

Significant risks/issues for escalation	None identified
Key issues/matters discussed at the Committee	• The committee was quorate; • The quality report contained June 21 and July 21 data. • The quality and safety report information was discussed and assurance gained; a combination of manual and automated data collection continues to be utilised; • Timely availability of performance data to ensure pre committee discussion at service leads is a challenge at times and will need to be managed at an operational level; • Based on the quality indicator data available to Q&S Committee there were no concerns regarding the quality of services currently provided by the Trust; • No Serious Incidents (SI) were reported during the reporting period • An increase in incident reporting for July was noted (and recognised as good practice) and acknowledged as appearing significant only due to the numbers being relatively low. No themes were identified however the increase will be monitored and incidents followed up appropriately • Six complaints had been received and investigations are being conducted; • The Committee was informed of the positive progress being made towards the appointment of substantive Safeguarding and IPC leads/posts • The Practice Based Pharmacy Quality Impact Assessment was presented, discussed and assurance gained; • Verbal updates were given on the work of the Quality and Safety Steering Group (QSSG). The QSSG received information on the ICS Quality Oversight Meetings. The Medical Director(s) and the Director of Nursing, Quality and AHPs are attendees. • The Quality & Safety perspective on the DIHC Business Plan was discussed and the need to ensure that the Quality Objectives are integral to service operational plans. A mid-year update report on delivery of the Quality Objectives is to be provided. At the time of Committee reporting the Covid data was as follows: • Staff Covid vaccination programme. A lower uptake of vaccination remains amongst patient facing staff; the report, as of 09/08/21,

	demonstrated an organisational level of vaccination differentiated as follows; 1st vaccinations - 89% of patient facing staff and 100% of non-patient facing staff vaccinated. Trust-wide compliance at 90% And; Fully vaccinated - 85% of patient facing staff and 94 % of non-patient facing staff vaccinated. Trust-wide compliance at 86%. • High Oak patient vaccination data was provided to Committee for assurance; • Team and service managers continue to promote Covid vaccination; **Clinical Governance systems:** • An updated progress report was provided to Committee on the governance developments (update included Datix deployment, Integrated Assurance Framework, Policy development & clinical audit) and assurance gained; **Board Assurance Framework & Risk Register:** • The Board Assurance Framework and Risk Register were reviewed alongside associated scoring, mitigation, controls, assurances and actions; this included a detailed discussion on EMIS implementation for the school nursing service.
Decisions made by the Committee	• None
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• None
Items/Issues for referral to other Committees	• None

Enclosure 9

NHS
Dudley Integrated Health and Care
NHS Trust

Workforce Performance Report

Reporting Period: July 2021

Reported At: August 2021, People Committee

Reported By: Bev Edgar, Interim Director of People

2021/22 Workforce Performance Report – Month 4

Page 3 – High level key for monitoring performance and assurance icons

Page 4 – HR Summary - Turnover, Vacancy and Sickness absence

Page 5 – Vacancies by Team – Month 4

Page 6 – HR Training Summary – Compliance by Training Module and Directorate

Page 7 – Additional Training Summary

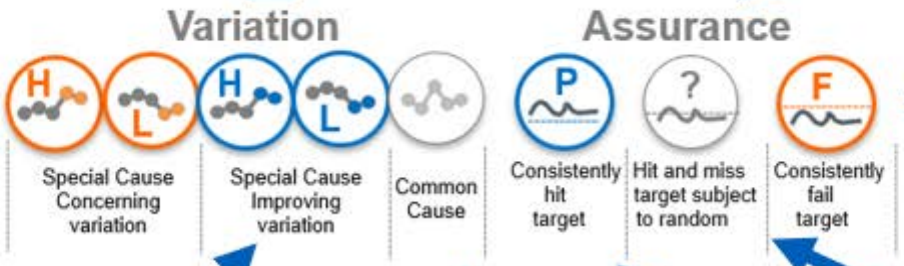
High level key for monitoring performance and assurance icons

Are we improving declining or staying the same

Can we reliably hit the target

Orange = system change required to hit target

Orange = significant concern or high pressure



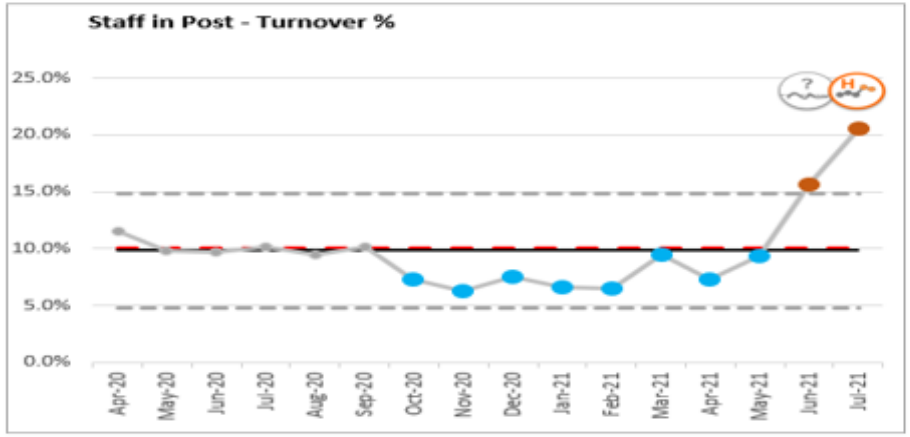
Hit and miss the target

Blue = significant improvement or low pressure

Grey – no significant change

Blue = will reliably hit the target

HR - Summary



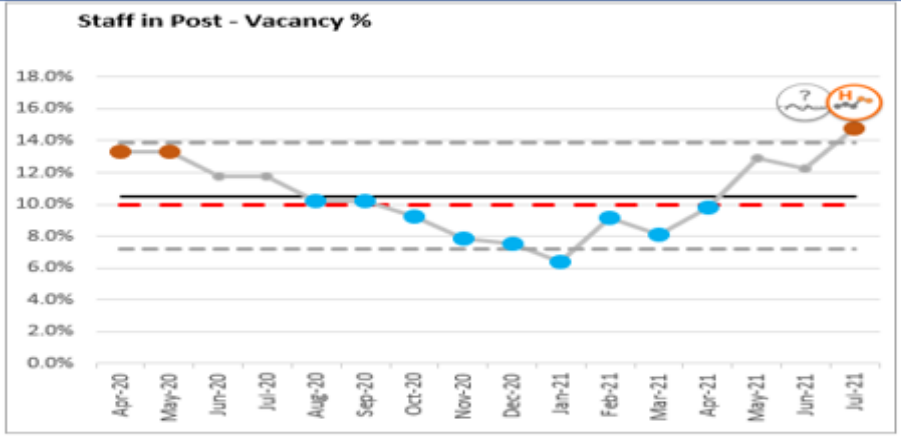
Latest Data
Jul-21

Performance

Special cause of concern. This occurs when performance is deteriorating.

Assurance

The system will not consistently hit or miss the target.



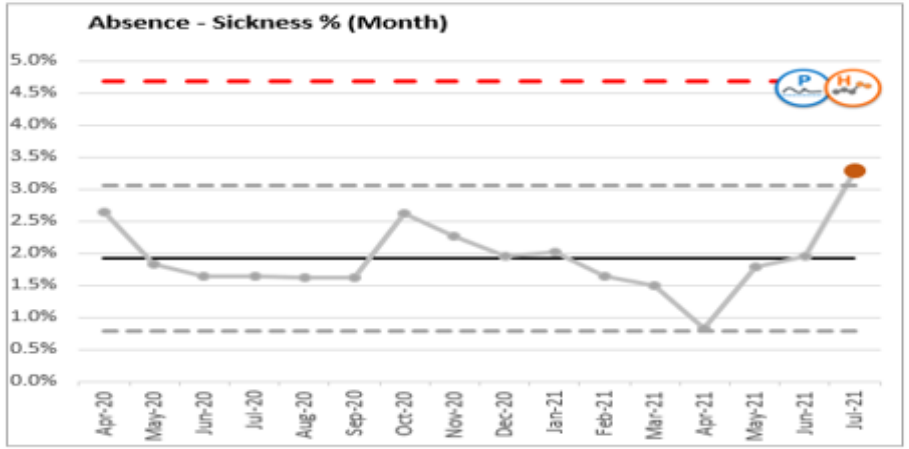
Latest Data
Jul-21

Performance

Special cause of concern. This occurs when performance is deteriorating.

Assurance

The system will not consistently hit or miss the target.



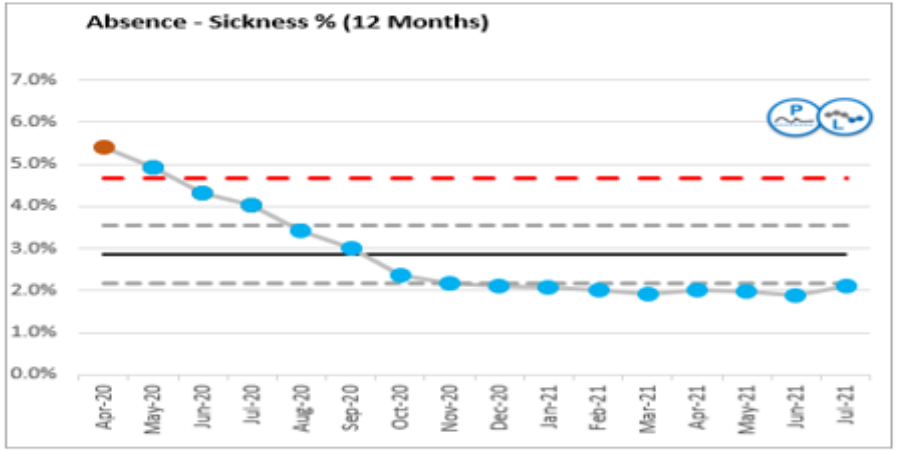
Latest Data
Jul-21

Performance

Special cause of concern. This occurs when performance is deteriorating.

Assurance

The system is capable and will consistently pass the target.



Latest Data
Jul-21

Performance

Performance is significantly improving.

Assurance

The system is capable and will consistently pass the target.

Service Commentary

- The funded establishment for July 2021 is 295.75 WTE. There were 30.75 new starters with the majority being the new Pharmacists.
- Current absence reporting highlights * employees being actively managed for long term sickness absence.
- 18 people recorded sickness absence in the month of July totalling 248 FTE days lost due to sickness.
- COVID vaccine compliance as at 9th August is 89% for patient facing staff and 100% for non patient facing giving overall compliance of 90%.There is a 86% for compliance for staff who have had the second dosage.

Please note: ** represents suppressed data as 5 to less*

Actions

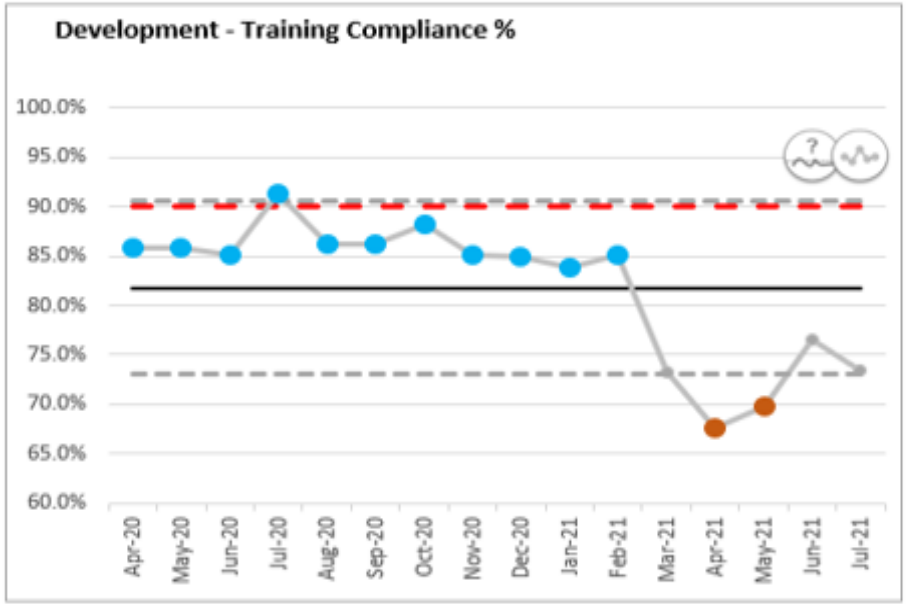
- As of the 12th August 2021 – There are 7 roles out for advert, 5 posts which are being shortlisted and 4 at the interview stage. Also, there are 25 roles at either the employment check stage or awaiting start dates.
- Finance, BI and Workforce to develop a process to ensure the establishment is updated monthly to enable accurate reporting.

Vacancies by Team – Month 4

This is the organisations current understanding level of vacancies.

Cost Centre	Number of Vacancies	Comments
CORPORATE	14.86	The recruitment plan was finalised by the Executive team on the 10th August 2021. The vacancies within the corporate team will be updated inline with new corporate structures.
CONTINUING HEALTHCARE AND INTERMEDIATE CARE	3.6	The social worker positions have been job matched and are in the recruitment process.
DUDLEY PRIMARY CARE MH TEAM	5.83	These posts are out for advert.
HIGH OAK PRACTICE	2	These posts are currently being interviewed.
IAPT	15.08	Vacancies are out for advert and the training posts are in the process of being fulfilled
MEDICINES MANAGEMENT	3.26	2 posts are being interviewed for and the remaining post is to be advertised.
PCN	1.79	Additional posts are being recruited to in accordance with ARRS funding.
SAFEGUARDING	1.4	These post are out to advert.
SCHOOL NURSING	3.64	These will go to advert by the end of August.

HR - Training Summary



Latest Data

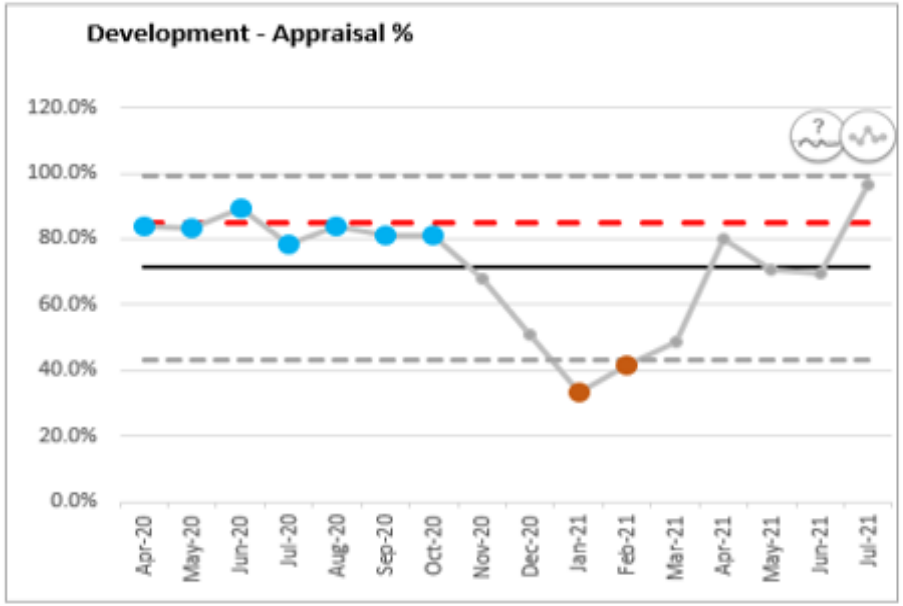
Jul-21

Performance

Common cause variation, no significant change.

Assurance

The system will not consistently hit or miss the target.



Latest Data

Jul-21

Performance

Common cause variation, no significant change.

Assurance

The system will not consistently hit or miss the target.

Service Commentary

- The training review has been completed in some areas mainly Safeguarding and IAPT teams. ESR modules will continue to be updated and further TNA's being undertaken across clinical and non clinical roles in order to inform the L&D Strategy. The outputs from this will be added to ESR accordingly.

- There has been improvement in some training modules which were highlighted as key areas of focus in June's report (*Please see next slide for details*). The non-training compliance notifications continue to be circulated with teams in order to improve the compliance rate. Feedback from the teams have proved that this strategy is useful and we will continue to provide a monthly report to service leads.

- Three training modules:
  Resuscitation - Level 2 - Adult Basic Life Support - 1 Year
  Clinical Risk Assessment - 3 Years
  Safeguarding Adults/Children Level 3 - 1 Year
  are classroom based training courses and have not been available during COVID. However, We are planning to run the Resuscitation - Basic life support training in September.

- Appraisal rate has reached 96.5% in July 2021. The Appraisal figure excludes all new staff who have not reached 1 years service with DIHC.

Actions

- BCH to confirm if classroom based training is being run virtually and when the classroom based training will re-start.

- Resuscitation - Basic life support training has been booked for 13th September 2021.

- How to chair a meeting is being held on the 10th September 2021. This will be advertised in the Friday round up communication email.

HR - Training Summary

Mandatory Training Compliance

Attribute	Total Compliant	Expiring Soon	Total Non Compliant	% Total Compliance
CSTF|Dementia awareness - No Specified Renewal|	46			100.00%
MAND|Mental Capacity Act - 3 Years|	18	2		100.00%
MAND|Mental Health Act - 3 Years|	15	2		100.00%
CSTF|Preventing Radicalisation - Prevent Awareness - 3 Years|	46		2	95.83%
CSTF|Health, Safety and Welfare - 3 Years|	229	8	20	91.97%
CSTF|Equality, Diversity and Human Rights - 3 Years|	228	8	21	91.57%
CSTF|Infection Prevention and Control - Level 2 - 1 Year|	44	10	5	89.80%
CSTF|Fire Safety - 1 Year|	214	20	35	85.94%
CSTF|Information Governance and Data Security - 1 Year|	209	22	40	83.94%
MAND|Medicines Management Awareness - 3 Years|	10	1	2	83.33%
CSTF|Moving and Handling - Level 1 - 3 Years|	205	7	44	82.33%
MAND|Domestic Violence and Abuse - 3 years|	13		3	81.25%
MAND|Safeguarding Adults Level 3 - 1 Year|	13	1	3	81.25%
MAND|Safeguarding Children Level 3 - 1 Year|	13	1	3	81.25%
CSTF|Safeguarding Adults (Version 2) - Level 2 - 3 Years|	85	2	20	80.95%
CSTF|Safeguarding Adults (Version 2) - Level 1 - 3 Years|	199		50	79.92%
CSTF|Safeguarding Children (Version 2) - Level 2 - 3 Years|	83	2	22	79.05%
CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	175	1	74	70.28%
CSTF|Infection Prevention and Control - Level 1 - 3 Years|	171	10	78	68.67%
CSTF|NHS Conflict Resolution (England) - 3 Years|	10	1	6	62.50%
MAND|Clinical Risk Assessment - 3 Years|	14		19	42.42%
CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	1		15	6.25%
Total	**2041**	**98**	**462**	**81.54%**

- The above charts show the breakdown of total compliance by training module and directorate.
- In order to meet the 90% training compliance target, we need to focus our attention on those modules highlighted by the red square.
- Three training modules:
  Resuscitation - Level 2 - Adult Basic Life Support - 1 Year
  Clinical Risk Assessment - 3 Years
  Safeguarding Adults/Children Level 3 - 1 Year
  are classroom based training courses and have not been available during COVID. However, We are planning to run the Resuscitation - Basic life support training in September.
- There has been an 3.3% point (p.p.) Improvement in those training modules which were highlighted in July's People committee for June's data as areas for focus. *(See chart on the right).*

Key Competences Highlighted (in April 21) for Improvement	Apr	May	Jun	Jul	% (p.p.) Increase
NHS|CSTF|Health, Safety and Welfare - 3 Years|	73.0%	83.3%	88.0%	92.0%	3.9%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	72.2%	82.1%	87.6%	91.6%	3.9%
NHS|CSTF|Fire Safety - 1 Year|	66.5%	77.9%	82.6%	85.9%	3.3%
NHS|CSTF|Moving and Handling - Level 1 - 3 Years|	65.0%	74.5%	79.5%	82.3%	2.8%
NHS|CSTF|Information Governance and Data Security - 1 Year|	63.1%	76.8%	82.6%	83.9%	1.3%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	43.3%	56.7%	64.5%	68.7%	4.2%
Total Compliance %	**63.9%**	**75.2%**	**80.8%**	**84.1%**	**3.3%**

Enclosure 10

Dudley Integrated Health and Care NHS Trust

COMMITTEE ASSURANCE REPORT TO THE BOARD

Committee: People Committee

Date of meeting: 24th August 2021 (via Microsoft Teams)

Presented By: Martin Evans, Non-Executive Director

Significant risks/issues for escalation	• DIHC to consider the most effective Freedom to Speak Up structure as we move towards transfer of services
Key issues/matters discussed at the Committee	• The committee was quorate • The committee reviewed the risks allocated to the People Committee. No amendments were made to the risk register. • A brief update was provided on Organisational Development work which is the subject of an extra ordinary People Committee on 26th August 2021. • Assurance was provided that the transfer of Practice Based Pharmacists went well on 1st July and there were no areas of concern that needed reporting back to the committee. • The workforce performance report was reviewed. The committee acknowledged the significant improvements that have been made on the appraisal rates (previously an area of focus) which has increased to 96.5% as of July 2021. • The two key areas of focus were again vacancies and mandatory training. Assurance was provided that an appropriate recruitment plan is in place with current focus being on filling the clinical roles as opposed to the corporate roles. An update was provided on the high number of IAPT vacancies, the majority of which are training posts some of which are to be filled by recently qualified students and others by students enrolling on University courses next month. Primary Care Mental Health vacancies remain the main are of focus and assurance was provided on plans that are in place to address them. The committee acknowledged the focus and improvements that have been made over recent months in relation to mandatory training which has increased from 69.74% to 81.54% compliance since June. The committee welcomed the update that some of the classroom-based training courses are commencing again in September. • An update was provided on the work of the Equality, Diversity and Inclusion committee. • The committee received an update on the plans for this winters internal flu vaccine campaign and assurance that a system will be in place to capture regular data on staff uptake. • An update was provided on the National Staff Survey which commences in September and runs for a number of weeks through to December. The committee noted

	the importance and value of having a good completion uptake by DIHC staff and were provided assurance that a communication plan will be in place and regular response updates provided. The DIHC away day in October was discussed as a good mid-way point for the Board to be promoting the value and importance of staff making the time to complete the questionnaire. • An update was provided on the development of the Freedom to Speak Up strategy and it was updated that there had been no referrals to the identified Freedom to Speak Up Guardian since DIHC became a trust in April 2020. Following a healthy discussion, the committee agreed quite strongly that there was a need for DIHC to now move to having its own Freedom to Speak up Guardian, well known to all DIHC staff and for DIHC to be registered and recognised on the National Freedom to Speak Up Guardian directory. It was agreed that further work was needed on the policy, which is being refreshed, the Executive Team would look to ensure that the identified guardian had the necessary time and training to perform the role and a further update to be provided at the next meeting.
Decisions made by the Committee	Nil
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	No specific implications identified
Items/Issues for referral to other Committees	Nil

Enclosure 11

Dudley Integrated Health and Care NHS Trust

COMMITTEE ASSURANCE REPORT TO THE BOARD

Committee: **Equality, Diversity and Inclusion Committee**

Author of the Report: Paul Assinder, Chief Executive Officer

Date of meeting: 12th August 2021

Significant risks/issues for escalation	• None
Key issues/matters discussed at the Committee	The Committee met on Thursday 12th August 2021. The Committee received an update of the progress made against the EDI Objective and the supporting action plan and noted the following key points: <u>Engagement and Communications</u> • Following discussion, it was agreed that there was much work to do in understanding service user demographic data in terms of the EDI agenda. An action was taken to investigate what data and reporting was readily available with the aim to develop an engagement strategy which would start to address access to services and the provision of services in the right place at the right time that would be meaningful for service users, communities and staff. <u>Development of the Equality Objectives Strategy and Action Plan</u> • The Committee recognised that this was a complex piece of work and commended the team on the objectives work plan it had shared with the members. • It was agreed that further work was needed on developing an EDI strategy outlining the high-level strategic direction mapped to the EDI objectives and outlining the legislative and statutory obligations compliance. • The action plan would be used as the assurance that the Trust was compliant with legislation, national and regional requirements and best practise through the reporting of key deliverables, by defining what success would look like and define timescales. • The committee supported the development of the key performance indicators. • Following discussion, it was recognised that whilst there were a number of formal and informal routes whereby staff can raise concerns, including HR policies

	on grievances and disciplinary's, Freedom to Speak Up, Ask Paul and Drop in with Steph's Drop, supported by the visibility of the Executive and Senior Leadership Team there was still more to be done to strengthen the culture of what is unacceptable behaviour and setting standards to ensure no member of staff was suffering in silence. This included links in email signatures, strengthening of the induction process and a comms campaign to highlight all the mechanisms. <u>Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)</u> • The Committee received the WRES and WDES return which was submitted on 31st August. • Discussion was had on the workforce and Board Diversity targets set by Sir Simon Stevens in his Phase 3 Recovery Letter and the need to develop robust succession planning supported by strengthening learning and development a five-year action plan. It was agreed to be made explicit within in the Action Plan. • Workforce data on the protected characteristics was flagged as a concern, it was recognised that this was not just a Trust issue but across the NHS. Better use of ESR was discussed and it was agreed that whilst the responsibility was on the member of staff to disclose the information more could be done to highlight the need for why this data is important. <u>Black Country and West Birmingham ICS EDI Strategy</u> • The Committee received tan update from the People Board, specifically of the work of the Leadership and Culture work stream.
Decisions made by the Committee	• The next committee would be 9th September 2021
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• None identified

Items/Issues for referral to other Committees	• None identified

Enclosure 12

Dudley Integrated Health and Care NHS Trust

Finance and Performance Report

Reporting period: April 2021 to July 2021

Reporting to: August 2021 Finance, Performance and Digital Committee

Reported by: Matthew Gamage, Director of Finance, Performance and Digital

Contents

- Finance Dashboard Page 3
- Income and Expenditure Summary Page 4
- Balance Sheet Reporting Page 5
- Cashflow Forecast Page 6
- Better Payment Practice Page 7
- Performance Scorecard Page 8
- IAPT Performance Page 9

Finance Dashboard

The finance dashboard shows performance against the key financial metrics for Dudley Integrated Health and Care NHS for the period to July 2021. The dashboard includes the measures relating to the key indicators from the NHS Oversight Framework.

Indicator	Definition	Scoring criteria				Actual	Score
NHS Oversight Framework		**1**	**2**	**3**	**4**		
Capital Service Cover Rating	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	<1.25x	0.1	4
Liquidity Rating	Days of operating costs held in cash or cash equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)	92 Days	1
I&E Margin Rating	I&E surplus or deficit/total revenue	>1%	1-0%	0-(1)%	<(1)%	0.06%	2
Distance from Financial Plan	Year to date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/deficit	>0%	(1)-0%	(2)-(1)%	<(2)%	400.00%	1
Agency Rating	Distance from providers cap	<0%	0%-25%	25-50%	>50%	-39.46%	1
Overall Score						2	
Local Finance Indicators		**Green**	**Amber**	**Red**		**RAG**	
Expenditure - Pay	Variance to plan	>0%	(2)-0%	<(2)%		-4.6%	
Expenditure - Non Pay	Variance to plan	>0%	(2)-0%	<(2)%		-4.6%	
Income	Variance to plan	>0%	(2)-0%	<(2)%		4.7%	
BPP - no. of payments - NHS	Better Payment Practice Code - Number of payments made on time	>95%	75-95%	<75%		100.0%	
BPP - no. of payments - Non NHS	Better Payment Practice Code - Number of payments made on time	>95%	75-95%	<75%		100.0%	
BPP - value of payments - NHS	Better Payment Practice Code - Value of payments made on time	>95%	75-95%	<75%		100.0%	
BPP - value of payments - Non NHS	Better Payment Practice Code - Value of payments made on time	>95%	75-95%	<75%		100.0%	

Capital Service Cover measures the ability to pay for financial obligations such as loan principal and interest repayments. The YTD operating surplus does not cover the principal and interest elements of the loan from Black Country Healthcare NHS Foundation Trust.

Liquidity rating shows that the Trust has enough cash to cover 92 days of operating costs. This is as a result of holding around £2.3m cash which relates to loan funding received from Black Country Health in 2020/21.

I&E margin is positive as a small surplus is being reported, despite a break even plan. This is the reason for the extreme favourable distance from financial plan.

Pay costs are currently over plan, with vacancy levels being offset by the recruitment of additional ARRS staff above the budgeted level, and transfer of practice-based pharmacists from the CCG. Both ARRS and pharmacy staff increases are funded through additional **income**, leading to the favourable variance against the income plan

Non-Pay costs are over plan, as the trust is bringing forward investments in support to the full business case and trust expansion to utilise funding released by pay underspends within non-PCN staffing budgets.

Better Payment Practice code targets continued to be achieved for all measures in July 2021.

Income and Expenditure Summary

Surplus/(Deficit)

The overall reported position is a year-to-date surplus of £2,000, with a forecast surplus of £1,000.

Committee should note that forecasts are for the H1 financial planning period only, with a break-even position forecast for the H2 planning period. Income and expenditure budgets for this period will be adjusted upon agreement of the H2 system financial plan.

Income

The annual contract income budget is comprised of the £12,868,000 main contract income agreed as part of the wider ICS plan, plus £1m non-recurrent transformation income agreed with BCWB CCG.

PCN and other service income is reported against the relevant division.

	WTE Budget	WTE Worked	WTE Variance	Annual Budget £000's	H1 Budget £000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Forecast Variance £000's
Income	**0**	**0**	**0**	**(13,868)**	**(7,623)**	**(5,082)**	**(5,082)**	**(0)**	**(1)**
Expenditure									
Primary Care	7.81	9	-1.19	890	508	381	456	(75)	(42)
PCN Services	65.51	66.47	-0.96	(141)	(71)	(47)	(54)	7	10
Mental Health & Learning Disability	77.82	55.43	22.39	3,298	1,649	1,099	835	264	397
Children & Young People	29.07	26.8	2.27	1,224	612	408	364	44	62
Older Adults & Reablement	22.61	18.62	3.99	1,046	523	348	433	(84)	(126)
Pharmaceutical & Public Health	13.33	40.3	-26.97	1,195	597	398	394	4	17
Corporate Services	49.28	30.54	18.74	6,357	3,804	2,493	2,651	(158)	(316)
Total Expenditure	**265.43**	**247.16**	**18.27**	**13,868**	**7,622**	**5,081**	**5,078**	**3**	**1**
Surplus/(Deficit)								**2**	**1**

Expenditure

As in M3, expenditure is summarised in the divisions in which the organisation will operate from 1st April, with reasons for significant variances highlighted. A cost centre-level breakdown of the position is included within Appendix 1 to the report, but the reasons for significant divisional variances are as follows:

- **Primary Care Services** are overspent by £75,000, with a forecast overspend of £42,000, due to an overspend against Local Enhanced Services where the Trust has taken on additional services from the CCG. Budget to fund the cost of these services will be created from increased contract income upon agreement of the contract variation, and is included within the Forecast Outturn .
- In **Mental Health and Learning Disability Services** a high level of vacancies is causing an underspend of £264,000, growing to a forecast £397,000.
- The **Children and Young Persons Division** reports an underspend of £44,000 (forecast £62,000), due to vacancies in the School Nursing team.
- **Older Adults and Re-ablement** budgets are overspent by £84,000, due to a significant level of agency expenditure to cover vacancies in the Continuing Healthcare team. Following the recruitment of staff in these areas, the forecast overspend is expected to reduce once these staff come into post.
- **Corporate Services** report an overspend of £158,000, with budget report underspends offset by additional non-recurrent investments in support the development of the Full Business Case and incremental expansion. As previously noted, investments are being brought forward to utilise operational underspends, and will be flexed to meet the level of available resource as this becomes apparent through the year.

Balance Sheet Summary

	Actual Closing 2020/21	Actual May-21 Closing	Actual Jun-21 Closing	Actual Jul-21 Closing	Month on Month Movement
	£'000	£'000	£'000	£'000	£'000
Non-current assets					
Intangible assets	-	-	-	-	-
Property, plant and equipment	38	34	33	32	(1)
Other investments / financial assets	-	-	-	-	-
	38	**34**	**33**	**32**	**(1)**
Current assets					
Inventories	-	-	-	-	-
NHS receivables	1,238	2,604	735	810	75
Non-NHS receivables	686	23	842	976	134
Other current assets	-	-	-	-	-
Cash and cash equivalents	4,097	3,671	4,510	4,676	166
	6,021	**6,298**	**6,087**	**6,462**	**375**
Current liabilities					
Capital trade payables	-	-	-	-	-
Revenue trade payables	(2,777)	(3,146)	(2,820)	(3,280)	(460)
Borrowings	(1,133)	(1,133)	(1,133)	(1,133)	-
Deferred income	(333)	(587)	(714)	(593)	121
Other financial liabilities	-	(207)	(197)	(233)	(36)
Provisions	-	-	-	-	-
	(4,243)	**(5,073)**	**(4,864)**	**(5,239)**	**(375)**
Net Current Assets	**1,778**	**1,225**	**1,223**	**1,223**	**-**
Non-current liabilities					
Capital payables	-	-	-	-	-
Revenue payables	-	-	-	-	-
Borrowings	(1,700)	(1,133)	(1,134)	(1,134)	-
Deferred Income	-	-	-	-	-
Other financial liabilities	-	-	-	-	-
Provisions	(27)	(27)	(27)	(27)	-
	(1,727)	**(1,160)**	**(1,161)**	**(1,161)**	**-**
Total Net Assets Employed	**89**	**99**	**95**	**94**	**(1)**
Financed by					
Public dividend capital	2,321	2,321	2,321	2,321	-
Revaluation reserve	-	-	-	-	-
Other reserves	-	-	-	-	-
Income and expenditure reserve	(2,232)	(2,222)	(2,226)	(2,227)	(1)
Total Taxpayers' Equity	**89**	**99**	**95**	**94**	**(1)**

- The overall net assets position is broadly static in this financial year, reflecting the small surplus position reported as at M4.
- The cash position continues to be healthy at £4.7m and is forecast to be £2.2m by the year end.
- The increase in non-NHS receivables is mainly as a result of recharges of Practice Based Pharmacists to the relevant PCN. These posts were new in M4.
- The increase in revenue payables is as a result of accrued expenditure for goods and services that have been received but have not yet been invoiced or paid.

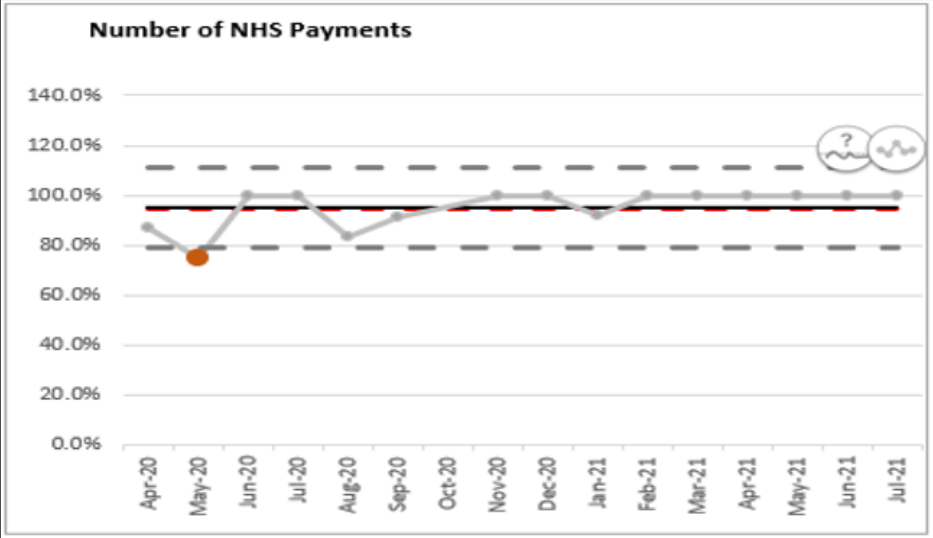
Cashflow Forecast

- The cash position is expected to reduce further by the end of the year following further loan repayments and the expected settlement of costs which have been accrued for.

- The forecast position still represents a healthy balance which will still provide the Trust with a significant favourable liquidity cover rating.

Better Payment Practice Code

Finance - Better Payment Practice Code



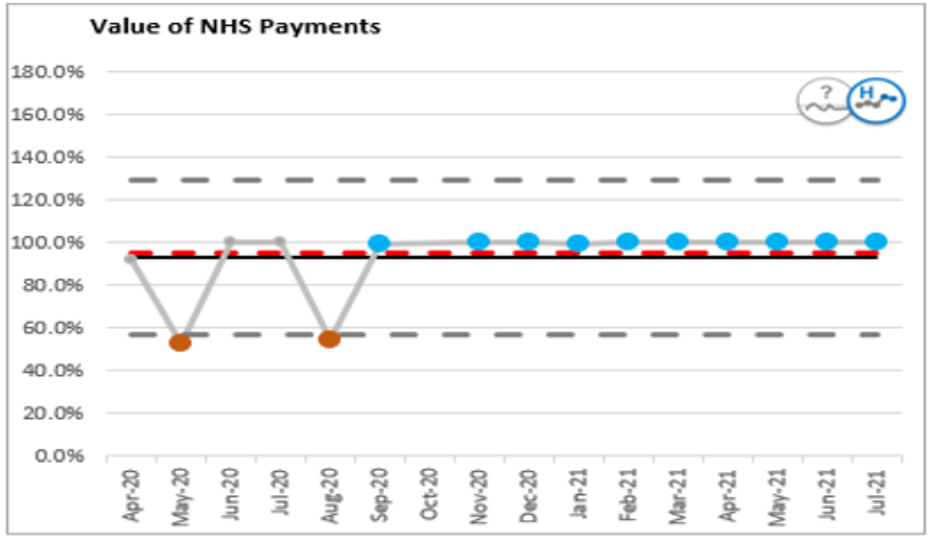
Latest Data	Target
Jul-21	95%

Performance

Common cause variation, no significant change

Assurance

The system will not consistently hit or miss the target.



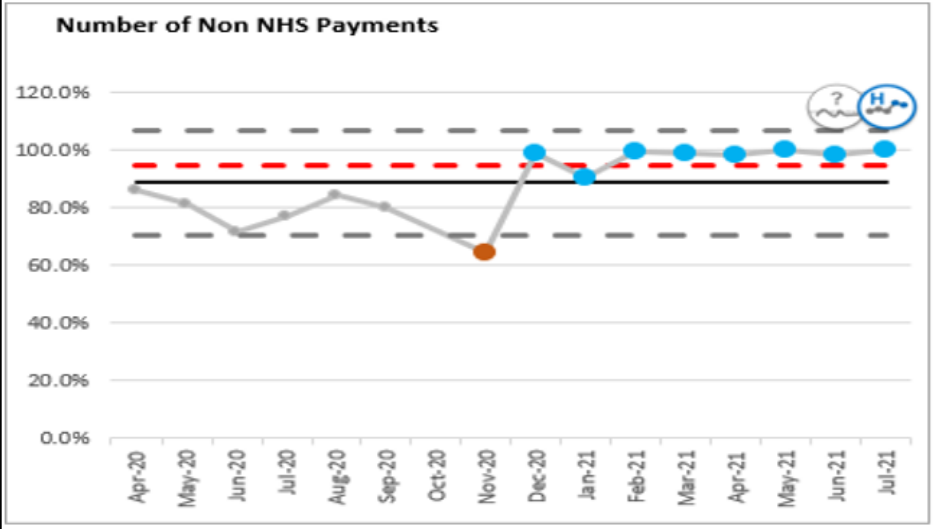
Latest Data	Target
Jul-21	95%

Performance

Performance is significantly improving.

Assurance

The system will not consistently hit or miss the target.



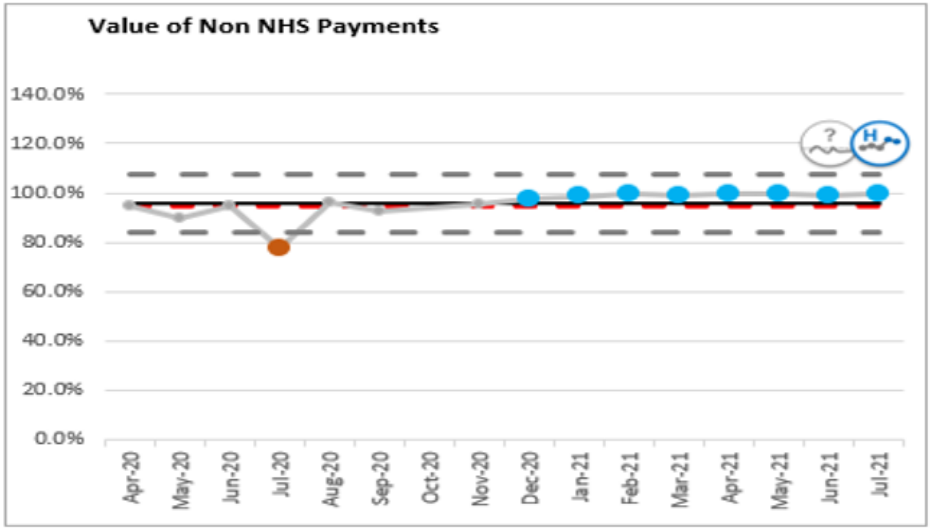
Latest Data	Target
Jul-21	95%

Performance

Performance is significantly improving.

Assurance

The system will not consistently hit or miss the target.



Latest Data	Target
Jul-21	95%

Performance

Performance is significantly improving.

Assurance

The system will not consistently hit or miss the target.

Dudley Integrated Health and Care Trust Scorecard 2021/22

IAPT	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Number of Service Users Referred for Psychological Therapies	Jul 21	797	0			624	401	847
Access Rate as a Proportion of Prevalence	Jul 21	1.4%	0.0%			1.4%	0.8%	2.1%
% of Service Users Entering Treatment	Jul 21	65.6%	100.0%		?	84.7%	47.6%	121.7%
% of Service Users Who Complete Treatment Who Are Moving to Recovery	Jul 21	50.0%	50.0%		?	44.4%	27.8%	61.0%
% of Service Users Who Are Treated Within 6 Weeks of Referral	Jul 21	92.0%	75.0%	L	P	97.3%	95.2%	99.4%
% of Service Users Who Are Treated Within 18 Weeks of Referral	Jul 21	95.6%	95.0%	L	P	98.6%	96.2%	101.0%

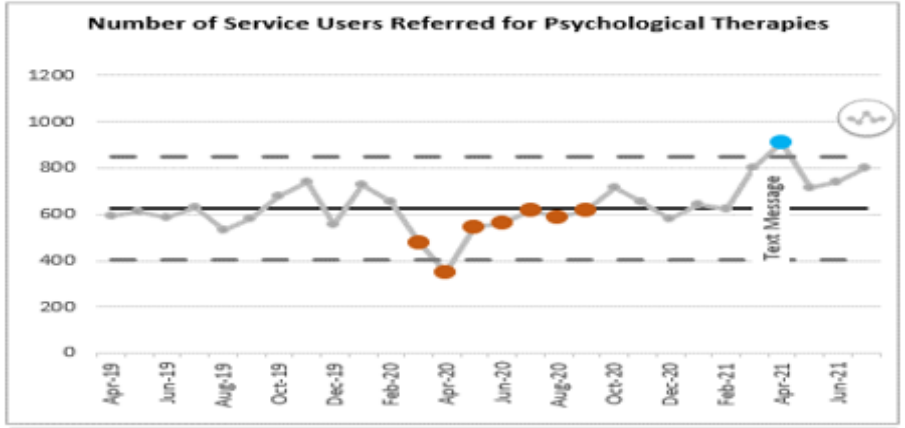
Key

Variation			Assurance		
	H L	H L	?	P	F
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Key points to note:

- The control limits have been set to pre-covid levels.
- The May and June IAPT figures have been refreshed following the national submission. The July figures are Indicative figures.

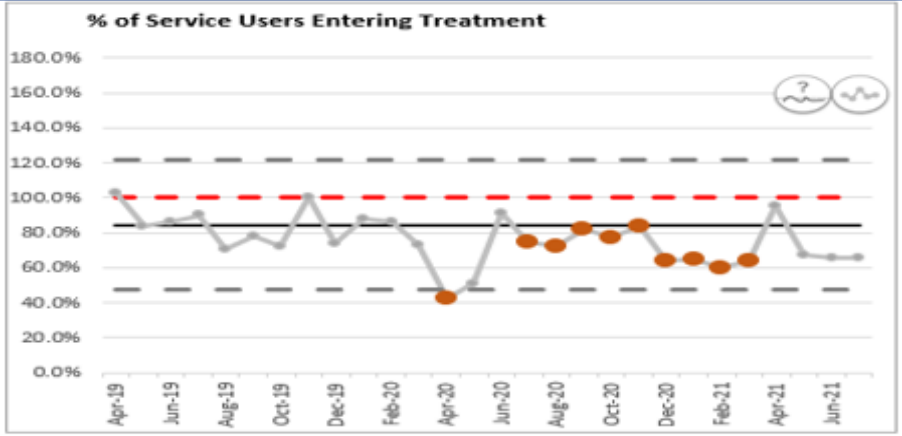
IAPT - Summary



Latest Data
Jul-21
Indicative Figures

Performance
Common cause variation, no significant change.

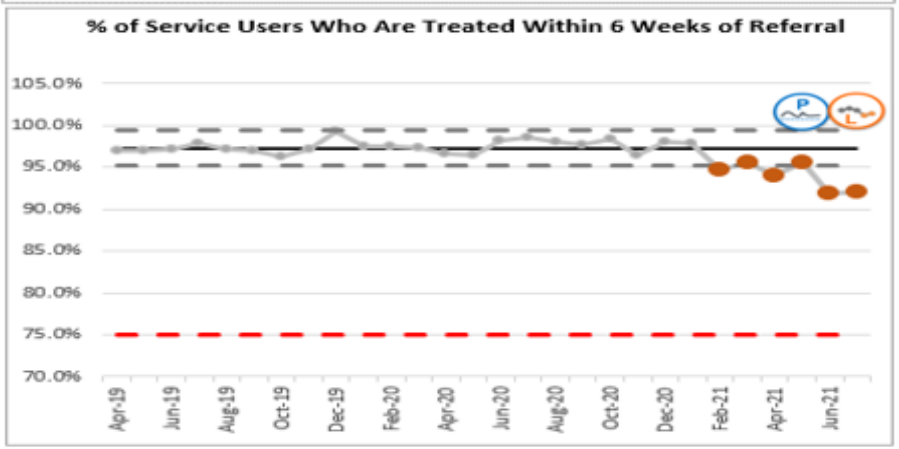
Assurance
The target has not yet been agreed



Latest Data
Jul-21
Indicative Figures

Performance
Common cause variation, no significant change.

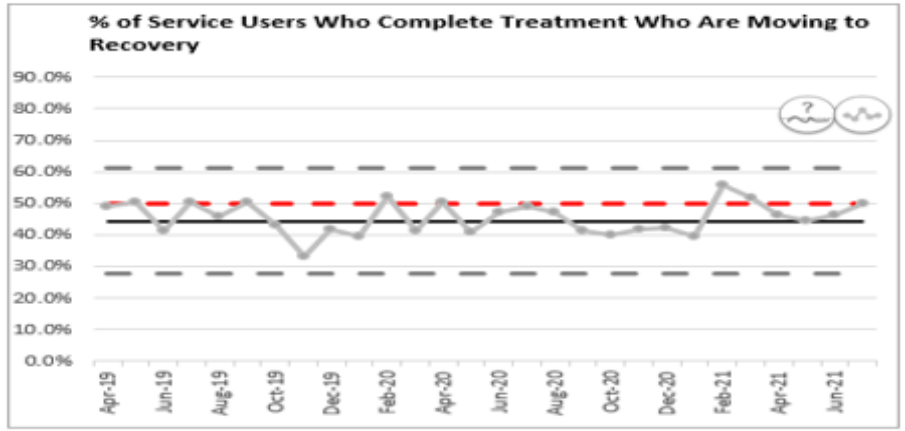
Assurance
The system will not consistently hit or miss the target.



Latest Data
Jul-21
Indicative Figures

Performance
Special cause of concern. This occurs when performance is deteriorating.

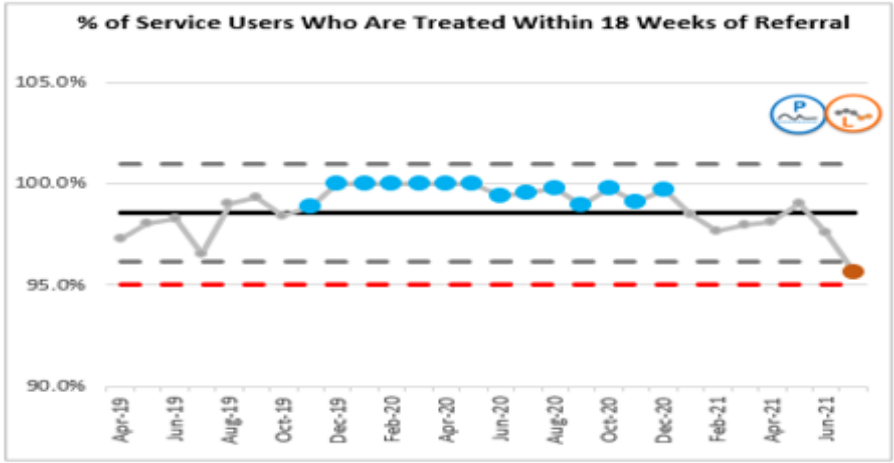
Assurance
The system is capable and will consistently pass the target.



Latest Data
Jul-21
Indicative Figures

Performance
Common cause variation, no significant change.

Assurance
The system will not consistently hit or miss the target.



Latest Data
Jul-21
Indicative Figures

Performance
Special cause of concern. This occurs when performance is deteriorating.

Assurance
The system is capable and will consistently pass the target.

Service Commentary

- A referral triage system is being implemented which is undertaken by the primary care mental health team.
- The impact of the introduction of an First Contact Practitioner for Mental Health in each PCN will also be reviewed. The DIHC early implementer FCP role. evaluation has shown that approximately 25% of patients seen are referred on to the IAPT service.
- The ICS Mental Health Programme Board have recognised the difficulties in achieving the IAPT performance targets across the Black Country due to other services that are available to patients. NB this point is linked to the point made above in relation to the new FCP roles.
- We are working with the sister PCMH team to look at how they can provide support to the waiting lists.
- The IAPT service has reimplemented the waiting list reviews and this has impacted on the 18 weeks wait time for a period of time as the review will have triggered certain people.
- The 6 weeks indicator has been affected by the reintroduction of the face to face support. A cohort of patients would or could only be seen by face to face and wanted to wait until restrictions eased.
- The IAPT Service has been given 2 training places for Person Centred Experiential Counselling and 1 place for Interpersonal Therapy by HEE. These training places will be recruited to shortly.

Actions

- May and June data has been refreshed as per the national submission timetable.
- The design of the delivery of mental health services within DIHC continues to be under review.
- A recruitment and retention strategy for staff is underway.
- Current vacancies are being shortlisted.

Enclosure 13

Dudley Integrated Health and Care NHS Trust

COMMITTEE ASSURANCE REPORT TO THE BOARD

Committee: **Finance, Performance and Digital Committee**

Date of meeting: 19th August 2021 (via Microsoft Teams)

Presented by: Ian Buckley, Non-Executive Director

Significant risks/issues for escalation	None identified

Key issues/matters discussed at the Committee	• The committee reviewed the risks allocated to FPD Committee
	  o The committee approved the addition of a new risk relating to EMIS and the data import for School Nursing Service. The project is now due to be completed during September following additional testing and data quality checks.
	• The committee received the Finance and Performance report related to the period April to July 2021
	• The Trust is reporting a year to date surplus of £2,000 and a forecast year end surplus of £1,000
	• Better Payment Practice Code is being achieved for both NHS and Non NHS payments, with 100% achievement against both standards in July 2021
	• The cash position continues to be healthy at £4.7m and is forecast to be £2.2m by the year end
	• 65.6% of the IAPT access target was achieved in July 2021 based on the monthly target for 2020/21
	• IAPT waiting time targets for both 6 weeks and 8 weeks had been achieved in July 2021, however performance has deteriorated in month as a result of the reintroduction of face to face appointments and waiting list inititiatives.
	• The recovery target was achieved in July with 50% of people completing treatment moving to recovery
	• The committee received a Business Intelligence progress update for assurance. Progress was noted for the following areas;
	  o Appointment of an information analyst
	  o School nursing EMIS templates completed and currently being tested by the team
	  o National community data submissions continue to be developed
	  o Implementing Data Quality Action Plan
	• The committee were assured by an update on progress to deliver the DIHC Three Year Green Plan and the ICS position for delivery of a system wide Green Plan for March 2022

Decisions made by the Committee	• The Committee were assured by the finance and performance report, the Board Assurance Framework, the Business Intelligence update and the progress made in relation to the Three Year Green Plan.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	No specific implications identified
Items/Issues for referral to other Committees	None identified

Enclosure 14

Dudley Integrated Health and Care NHS Trust

COMMITTEE ASSURANCE REPORT TO THE BOARD

Committee: **Primary Care Integration Committee**

Date of meeting: 18th August 2021

Presented by: Dr George Solomon, Non-Executive Director

Significant risks/issues for escalation	• None
Key issues/matters discussed at the Committee	• The Committee held a meeting on the 18th August 2021. • The key issues and actions are set out below **Primary Care Mental Health** • The Committee supported the re-purposing of the existing primary care mental health teams to provide 'first contact mental health practitioner' roles to primary care • The PCNs have identified and prioritised these roles within their workforce plans and unanimously supported this proposal. • Whilst DIHC have the remit to repurpose their existing team to fulfil the need in primary are, DIHC and the PCNs will be approaching NHSE to support this proposal with regards any additional national funding for posts as DIHC will need approval for that.. **PCN Update** • The Committee received an update from the PCNs. • The PCNs are currently recruiting into their ARRS roles as per their workforce plans, continuing to deliver the COVID vaccination programme, and are in the process of fully restoring services – practices and PCNs are experiencing high demand and a lot of pressure at present • Dr Tapparo, Clinical Director for the Brierley Hill PCN has resigned and will be leaving her role on 30th October 2021. • Dr Tapparo invited DIHC to put a proposal to the Brierley Hill PCN to nominate a DIHC GP employee as the Clinical Director, along with a proposed model for DIHC to effectively manage all aspects of the PCN DES on behalf of the PCN.

- It was agreed that the Executive Team would consider this request, and an update would be provided at the next Committee meeting. The PCNs will also be debating this in their meeting.

Head of Primary Care Update

- The Committee received an update on from the Head of Primary Care.

Chapel Street Surgery

- The Executive Team has considered a request from Chapel Street surgery to take on their GMS contract.
- The contractual and legal aspects of this have been considered, with the only viable option pre the anticipated award of the ICP contract being that the existing contract holders sub-contract to DIHC for the remainder of the financial year/until the award of the ICP contract.
- The Executive Team have agreed to taking on a sub-contract subject to a manager from DIHC working full time to manage the transition, and funded by the CCG.
- The Committee supported the recommendation of the Executive Team and sought ongoing assurance and updates each month.

Central Clinic

- The Committee received an update on a support team requested by the CCG, provided by DIHC to enable the practice to develop and implement an action plan in response improvements identified by the CQC.

Corporate Structure

- The Committee noted and supported the additional posts requested to enable the Committee to discharge its annual work plan.
- The additional posts have been requested specifically in support of quality improvement, PCN development and the operational management of full integration.

DIHC and PCN Service Level Agreement (SLA)

- The Committee received an update on the SLA – this is essential to have in place regarding DIHC employing and providing services on behalf of PCNs with ARRS resources that the PCNs are transferring to DICH.

	• 5/6 PCNs have entered into the SLA with the remaining PCN to commit and sign subject to some minor revisions. **High Oak Case Pre-Consultation Business Case** • The Committee received the pre-consultation business case for discussion and comment. • The Committee agreed to review and revise outside of the meeting with a view to endorsing the final draft in September 2021 before being submitted to Board for approval. **Committee Work Plan** • The Committee noted the work plan update and was assured that actions and mitigations were in place. **Risk Register & Board Assurance Framework** • The Committee reviewed and agreed the corporate risk register
Decisions made by the Committee	• The Committee supported the decisions of the Executive Team in relation to Chapel Street.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• None identified
Items/Issues for referral to other Committees	o None identified

Enclosure 15

Dudley Integrated Health and Care NHS Trust

COMMITTEE ASSURANCE REPORT TO THE BOARD

Committee: **Transaction and Transformation Committee**

Date of meeting: 10th August 2021 (via Microsoft Teams)

Significant risks/issues for escalation	None identified
Key issues/matters discussed at the Committee	• The committee reviewed the Board Assurance Framework and the Transaction Committee risk register and noted the recommended amendments. A full review of the risks will be undertaken prior to the next Transaction Committee meeting in September 2021. • The committee received an update on ongoing dialogue with NHSI and system partner colleagues. The committee were informed that significant progress has been made over recent weeks and in particular the support of the Clinical Senate to transfer community services from The Dudley Group NHS Foundation Trust to DIHC. This is subject to a number of conditions in including commitment from both organisations to improve relationships, to appoint an independent advisor to span both organisations, to produce and share a programme plan and to commence joint dialogue with staff with immediate effect. The transfer of services is also subject to the successful completion of a business case which will be subject to the necessary assurance processes. DIHC will complete the assurance process which will include the submission of a business case in the Autumn of 2021 to include the transfers of community and children's services and the anticipated award of an ICP contract to DIHC on 1st April 2022. The committee agreed that the priorities for DIHC remain which are to ensure the continued delivery of high quality existing services allowing DIHC to flourish, building relationships in the system, to maintain a sustainable organisation and to focus on the development of the Dudley place with system colleagues in line with ICS development plans. • The committee noted the current risks to successful submission of the business case to NHSI. The risks currently include the potential delayed submission of due diligence information and / or incomplete due diligence information which will significantly impact on the ability of DIHC to complete the business case to a satisfactory standard. The business case team will assess this situation once the due diligence information is due to have been submitted and will advise accordingly on whether the date of submission needs to be slightly delayed. • The committee considered the partners issues and risks log that has been produced to ensure that when submission of the business case takes place all issues

	and concerns have been raised and responded to accordingly. • The committee discussed in detail the progress that the DIHC business case production team are making in addressing the red flags from the strategic case and the concerns raised following the last submission of the business case in October 2020. • The draft structure of the business case was shared and approved by the committee. The structure has been produced following the layout of exemplary business cases that NHSI recommended were obtained by DIHC. • The draft structure of the Post Transaction Integration Plan (PTIP) was shared and approved by the committee. The structure has been produced following exemplary PTIP's that NHSI recommended were obtained by DIHC. • The Director of Finance provided an update on the development of the system financial model which is being led by the CCG and involves all NHS partners in the system. • The DIHC Development Plan was discussed by the committee. Areas of delayed progress and reasons for delay were noted by the committee. Committee members agreed to reflect on whether any additional risks based on delayed progress were required to be presented to Committee in September 2021. • The committee reviewed the Business Case Risk Register which is also shared with partners and presented at the Business Case Engagement Forum. The Risk Register incorporates any risks to the successful completion and submission of the business case through to the transfer of services and award of contract.
Decisions made by the Committee	• None.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	None identified.
Items/Issues for referral to other Committees	None identified.

Enclosure 16

Dudley Integrated Health and Care NHS Trust

DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

TITLE OF REPORT:	2020/21 Annual Report and Accounts
PURPOSE OF REPORT:	To receive the 2020/21 Annual Report and Accounts
AUTHOR OF REPORT:	Elaine Doyle, Trust Secretary Harry Turner, Chair
DATE OF MEETING:	8th September 2021

KEY POINTS:	The board delegated to the Chief Executive Officer as Accountable Officer and Director of Finance, Performance and Digital, as Chief Financial Officer, the recommendation for final approval of the 2020/21 Annual Report and Accounts before submission to NHSEI on 30th June 2021.
	
	At the Extra-Ordinary Audit and Risk Committee on 28th June 2021 the committee approved the annual report and accounts for submission. The Board are asked to note the auditors' findings below:
	
	• Independent auditor's report to the Directors of Dudley Integrated Health and Care NHS Trust Report on the Audit of the Financial Statements, following completion of the audit, find the financial statements:
	  o give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended;
	  o have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
	  o have been prepared in accordance with the requirements of the National Health Service Act 2006.
	
	Following submission of the annual report on the 28th June, the draft report has been through the publishing process and the final report is attached.
	
	The Annual Report and Accounts will be presented to the public at the Annual General Meeting on Wednesday 8th September 2021.

RECOMMENDATION:	• To note decision of the Audit and Risk Committee on 28th June 2021 and the submission • To note the Auditor's Report and Opinion

ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:	None identified
ACTION REQUIRED:	Decision ☐
	Approval ☒
	Assurance ☐

NHS
Dudley Integrated Health and Care
NHS Trust

Annual Report

2020/21

01 Chair and Chief Executive's Foreword

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

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

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

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

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

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

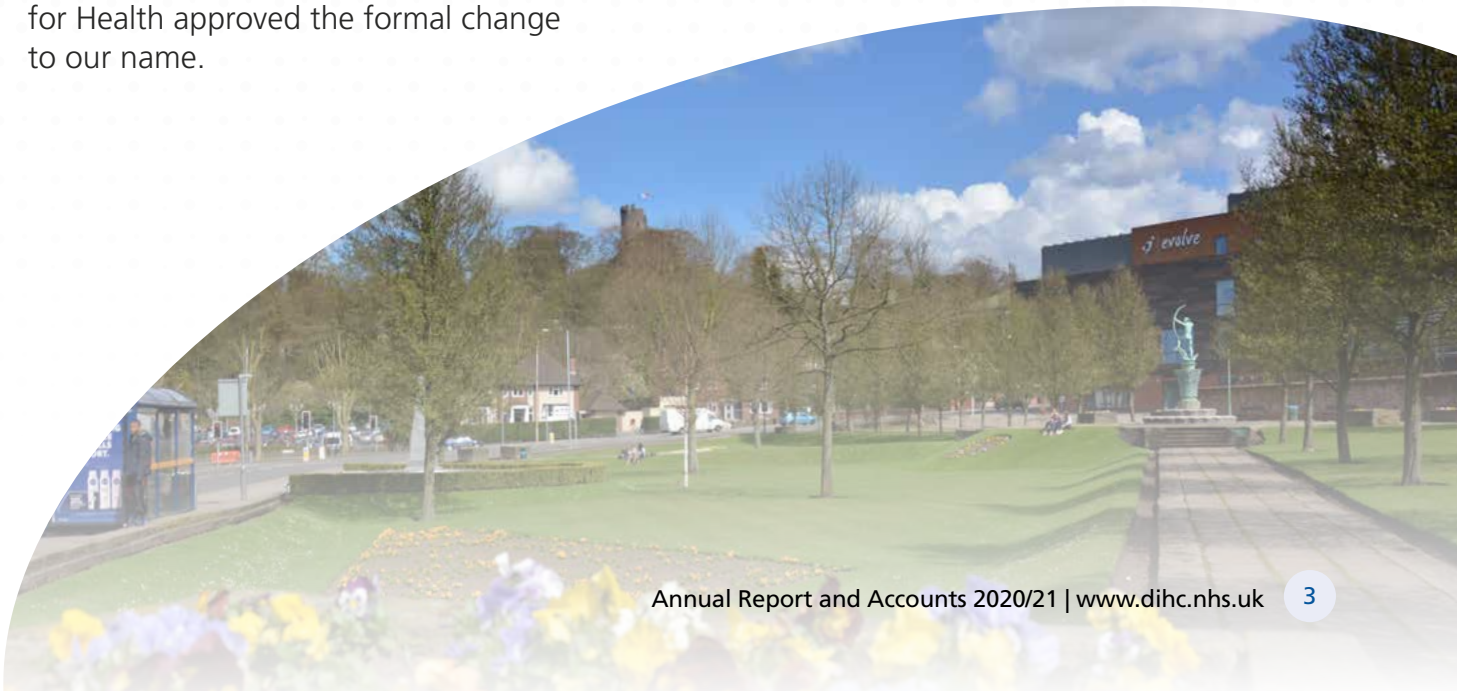
We were created in April 2020, through the re-designation of a former local NHS body Dudley and Walsall Mental Health Partnership NHS Trust (DWMH) and have inherited some of their services *(the others transferring to the newly established Black Country Healthcare NHS FT)*. We formally changed the Trust's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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

Harry Turner
Chair

Paul Assinder
Chief Executive Officer

02 Contents

Chair and Chief Executive's Foreword 2

Contents 6

Performance Report 7

- Performance Overview 7
- Performance Analysis 26

Quality, Safety and Experience 29

Accountability Report 56

- Corporate Governance Report 56
- Remuneration and Staff Report 88
- Independent Auditor's Report to the Directors of Dudley Integrated Health and Care NHS Trust 102

03 Performance Report

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

Performance Overview

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

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

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

Our Trust, Our Staff and Our Services

Our Trust

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

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

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

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

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

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

2020/21 Statistics

The Trust serves

328,093[1] people

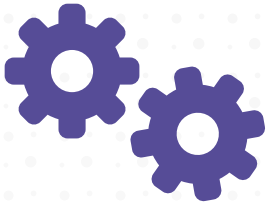
1 Dudley CCG registered population (Mar 2021) https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/march-2021

Total Employees (31st March 2021)

221

Number of Sites

3



Number of Main Commissioners

2

Total Income (£000's)

£10,888

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

£7,215

Other Patient Care Income (£000's)

£938

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

£2,735

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

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

Our Staff

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

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

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

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

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

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

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

Our Services

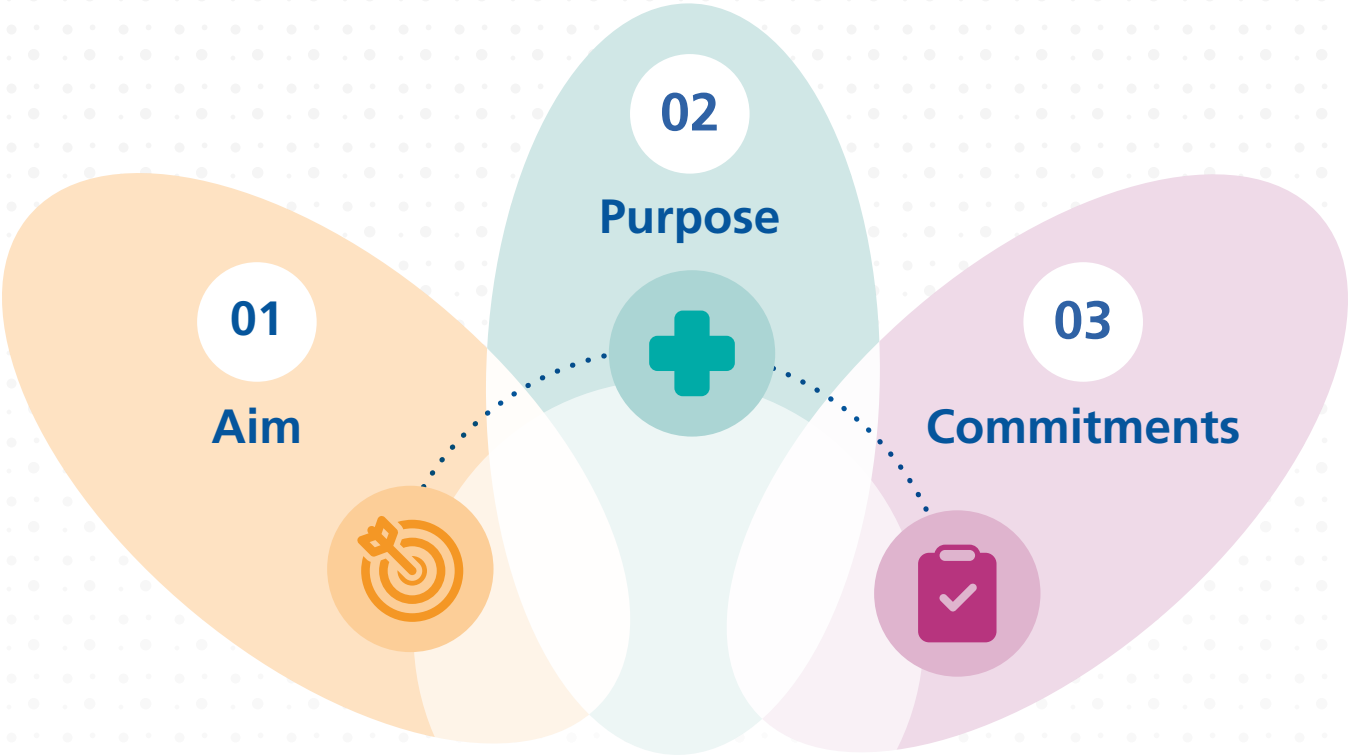
Our clinical services are summarised below.

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

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

Our Aim, Purpose and Commitments

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



Aim

Dudley first: community where possible, hospital where necessary.

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

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 or ask us to.
- Empower our service users to be joint decision makers in their care.

Enable and support our staff

We will:

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

Simplify what can be complex

We will:

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

Be accountable for our actions

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

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

Our Key Achievements in 2020/21

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

A Year of Clinical Achievement

Mental Health Services

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

The Pensnett Respiratory Assessment Centre (RAC)

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

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

High Oak Surgery

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

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

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

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

As a consequence:

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

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

Pharmaceutical Services

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

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

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

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

Continuing and Intermediate Healthcare

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

Research & Development

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

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

Our Key Achievements in 2020/21
continued

A Year of Cementing our relationships with Primary Care

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

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

A Year of working with service users and local communities

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

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

A Year of working with System Partners

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

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

A Year of good governance and financial probity

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

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

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

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

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

Performance Against Our Objectives

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

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

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

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

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

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

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

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

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

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

Looking forward

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

Award of the ICP contract to DIHC

Integrate and develop existing services

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

Develop and deliver the DIHC Organisational Development Strategy

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

Development of the working partnership between DIHC and Primary Care

Work with the system partners to restore services effectively

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

Demonstrate effective use of resources and be a sustainable organisation

Develop the full Integration Strategy for Primary Care

Our Key Risks and Issues

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

The eight key risks to our plans were identified as:

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

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

Going Concern

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

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

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

Impact of COVID-19

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

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

COVID-19 Assessment Centre

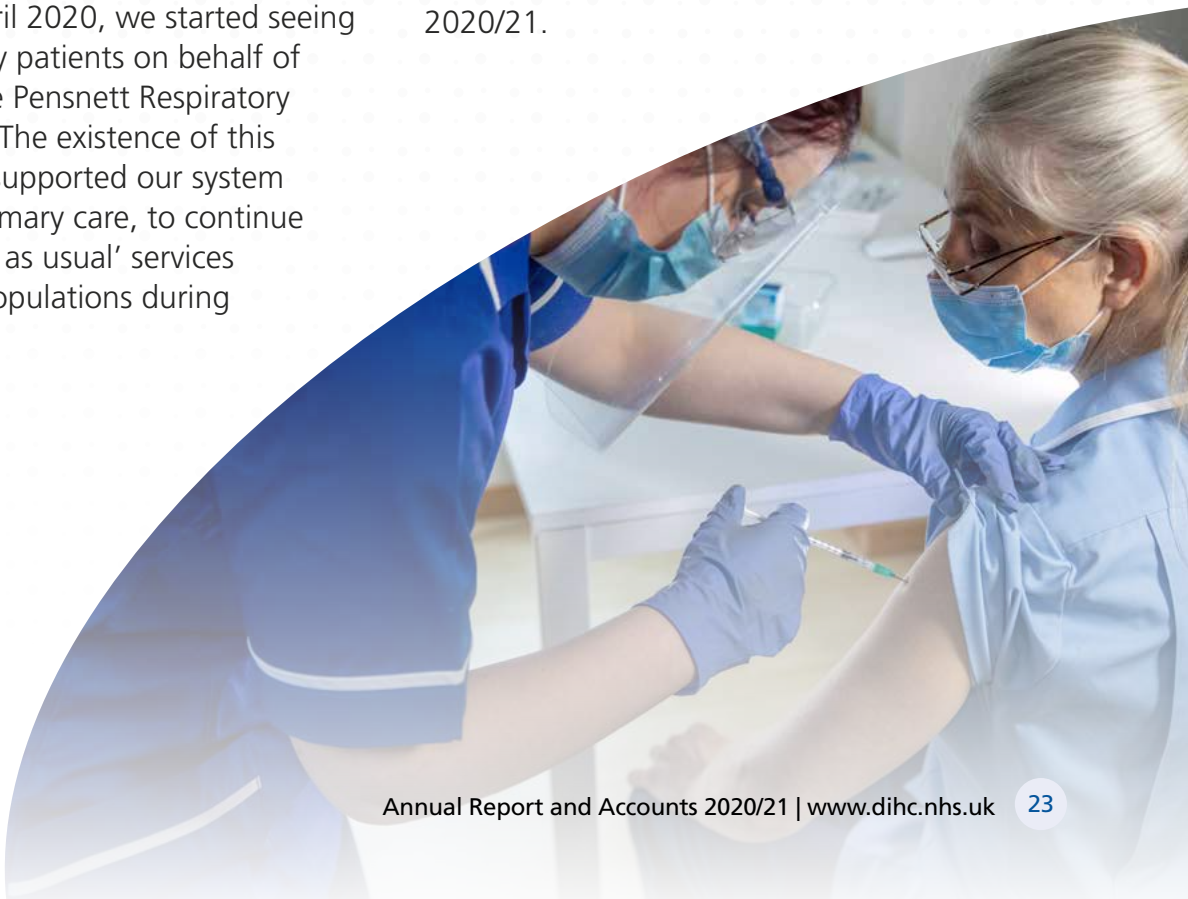
Following the first national lockdown on 23rd March 2020, DIHC was commissioned on its first day of existence (1st April 2020) to operate a COVID-19 assessment centre. Three working days later, on 6th April 2020, we started seeing out first COVID-likely patients on behalf of all Dudley GPs at the Pensnett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

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

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

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

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



Impact of COVID-19 on our other services

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

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

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

Impact of COVID-19 on our staff

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

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

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

CASE STUDY

Health coaching at Lion Health

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

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

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

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

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

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

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

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

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

Performance Analysis

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

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

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

Performance Dashboard

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

Dudley Integrated Health and Care Trust Scorecard 2020-21

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

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

Points to note:

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

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

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

Managing Performance

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

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

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

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

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

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

04 Quality, Safety and Experience

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

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

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

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

Our Quality Priorities

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

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

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

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

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

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

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

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

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

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

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

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

Incident Reporting and Management

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

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

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

No Never Events have been reported during 2020/21.

Clinical Audit and Effectiveness

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

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

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

Pharmaceutical Public Health Team

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

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

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

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

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

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

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

Research and Development undertaken in year includes:

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

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

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

Care Quality Commission (CQC)

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

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

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

Health and Safety

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

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

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

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

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

Incident investigations

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

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

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

HSE Inspectors

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

Emergency Planning

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

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

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

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

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

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

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

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

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

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

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

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

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

Service User and Staff Voice Summary

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

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

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

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

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

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

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

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

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

Involving and listening to our service users

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

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

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

Service User Experience

Complaints, Concerns and Compliments

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

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

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

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

Involving and listening to our workforce

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

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

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

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

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

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

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

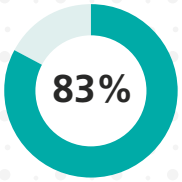
Across the Trust there a number of ways in which we engage and communicate with our staff including:

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

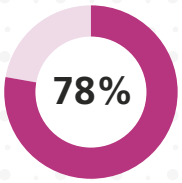
- Fortnightly `Ask Paul' session for all staff to attend and ask any question of our Chief Executive and our Executive management team.
- Monthly DIHC Development sessions for all staff with our Director of Operations, Strategy and Partnerships/Deputy Chief Executive updates staff on the development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

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

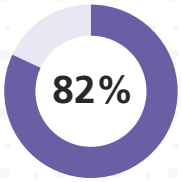
All responses were above **75% positive**, and some highlights are:



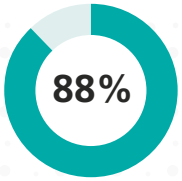
of staff feel welcomed and part of the team by DIHC



of staff feel communication is effective

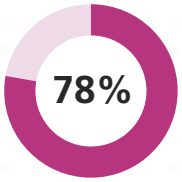


of staff feel their voice is heard

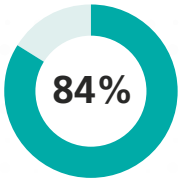


of staff feel their health and wellbeing is important to DIHC

of staff feel trusted to do their job



of staff would recommend DIHC as a place to work



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

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

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

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

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

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

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

Health and Wellbeing of our Staff

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

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

Involving Our Partners and Stakeholders

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

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

These transfers are as follows:

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

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

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

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

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

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

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

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

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

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

CASE STUDY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Equality, Diversity and Inclusion Summary

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

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

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

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

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

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

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

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

Our successes and achievements

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

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

Sustainability and the Net Zero NHS Ambition

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

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

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

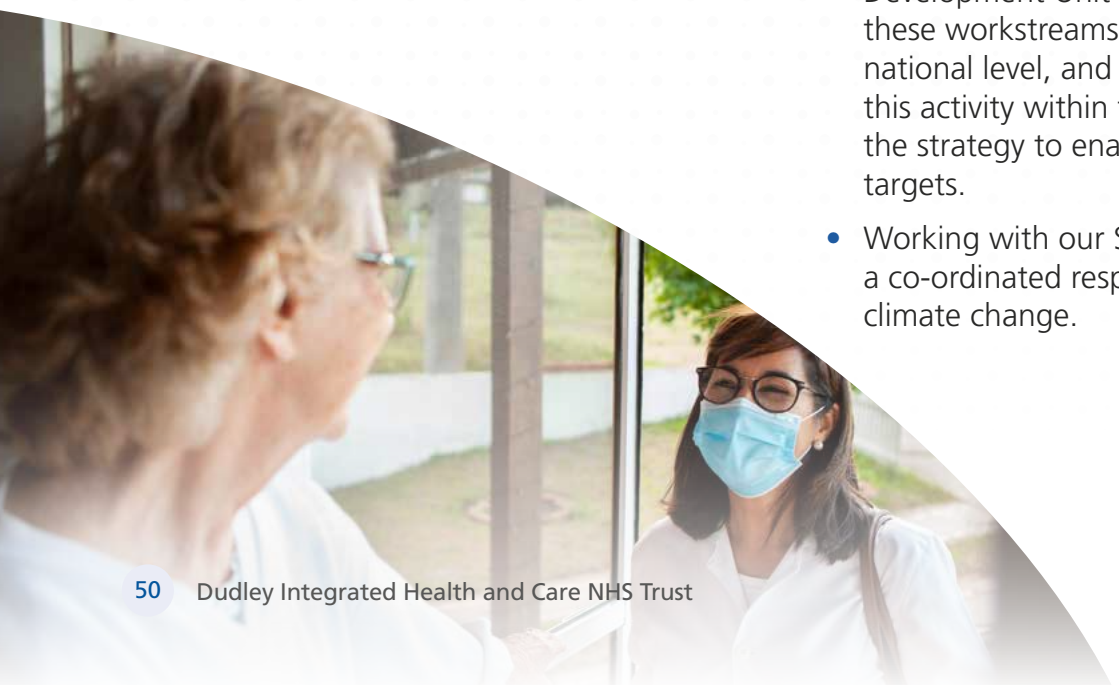
We appointed a Non-Executive Director (NED) and Executive Director as leads for Sustainability and continued working with our STP partners to ensure a co-ordinated response to the impact of climate change.

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

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

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

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



Financial Summary

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

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

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

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

Where does the Trust's Income come from?

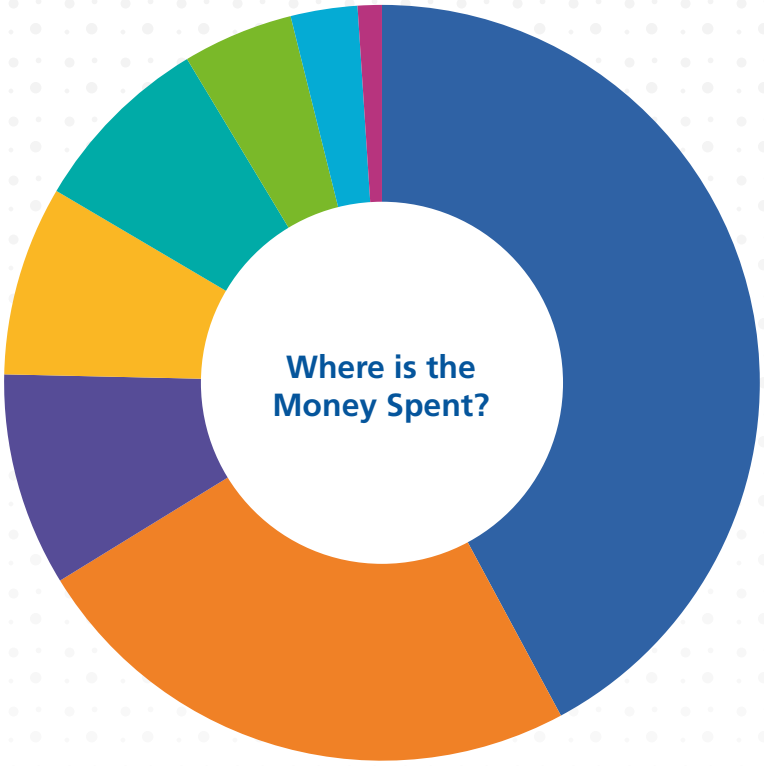
The majority of the operating income is receivable under a contractual arrangement from NHS Dudley CCG as lead commissioner. However, the COVID-19 pandemic resulted in the suspension of existing arrangements and implementation of a new national financial regime in which income became receivable on a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

How is the Trust's money spent?

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

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

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



Corporate Services
£4,573

Primary Care Services & Networks
£857

Mental Health Services
£2,613

Continuing Healthcare Management
£514

Operational Delivery, Quality and Governance
£990

Medicines Management
£310

COVID-19 Response
£881

Non-operating expenses
£112

Capital Expenditure

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

Payment of Suppliers

Better Payment Practice Code

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

Better Payment Practice Code Performance

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

Countering Fraud, Bribery and Corruption

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

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

The four key principles are:

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

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

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

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

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

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

Signed.....

Chief Executive

Date: 28th June 2021

Brambles

05 Accountability Report

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

The Accountability Report has three elements:

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

Corporate Governance Report

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

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

The Directors' Report

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

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

The Trust Board

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

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

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

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

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

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

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

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

Our Board members' roles and skills are summarised below.

Trust Board members 2020/21

Non-Executive Directors

Harry Turner, Chair

Appointed on 1st April 2020

Chair of:

- Trust Board
- Trust Board Appointment and Remuneration Committee
- Transaction Committee

Harry has extensive experience, having served as a Non-Executive Director and then Chairman of Worcestershire Acute NHS Trust between 2008 and 2016.

He also took up the position of Chairman of the John Taylor Hospice in Birmingham October 2016 and was also a Non-Executive Director on Dudley and Walsall Mental Health NHS Trust.

Harry has also been a Justice of the Peace in Worcestershire Courts for more than a decade.

He previously worked as an Operations Director in the hotel industry, working for businesses including Travel Inn and Marriott International.

Ian Buckley, Deputy Chair and Senior Independent Director

Appointed on 1st April 2020

Chair of:

- Finance, Performance and Digital Committee

Member of:

- Trust Board Appointment and Remuneration Committee
- Quality and Safety Committee
- Transaction Committee
- Primary Care Integration Committee

Ian has worked as Chief Executive for a number of UK and US businesses and served on both PLC and private company boards.

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

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

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

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

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

Non-Executive Directors

David Gilburt, Non-Executive Director

Appointed on 1st April 2020

Chair of:

- Audit and Risk Committee

Member of:

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

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

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

Valerie Little, Non-Executive Director

Appointed on 1st April 2020

Chair of:

- Quality and Safety Committee

Member of:

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

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

Non-Executive Directors

George Solomon, Non-Executive Director

Appointed on 1st April 2020

Chair of:

- Primary Care Integration Committee

Member of:

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

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

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

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

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

Martin Evans, Non-Executive Director

Appointed on 1st April 2020

Chair of:

- People Committee

Member of:

- Trust Board Appointment and Remuneration Committee
- Audit and Risk Committee
- Finance, Performance and Digital Committee
- Transaction Committee

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

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

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

Executive Directors

Paul Assinder, Chief Executive

Appointed on 1st April 2020

Attendee of:

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

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

Paul is one of the most experienced and respected Chief Financial Officers currently working in healthcare in the UK. He was elected as National President of the Healthcare Financial Management Association (HFMA), the leading professional body for finance staff working in UK healthcare, in December 2009. Doubly qualified as an accountant, with a University background in both economics and management, he trained and worked with Ernst & Young Co in the UK after graduation before specialising in the healthcare and technology sectors.

Stephanie Cartwright, Interim Director of Operations, Strategy and Partnerships and Deputy Chief Executive

Appointed on 1st April 2020

Attendee of:

- Quality and Safety Committee
- Finance, Performance and Digital Committee
- Transaction Committee
- Primary Care Integration Committee
- People Committee
- Equality, Diversion and Inclusion Committee

Stephanie is responsible for the operational management of the services within the Trust, and is the executive lead for strategy development and partnership working. Stephanie also has responsibility for strategic organisational development.

Stephanie has responsibility for the day to day operation of our organisation and services, the development of our organisational strategies and for managing our relationships with our partners and stakeholders. Stephanie has over 25 years' experience of working with the Health Service. Her professional background is in organisational development, management and leadership and she has held a Board level role for eight years. For the last five years, Stephanie has been involved in the development of the ICP new care model in Dudley as the Programme Director, and more latterly as the Interim Managing Director for the ICP development; a role she has undertaken for the last 18 months. Stephanie is passionate about the transformational change that the ICP will bring to the way health and care services are delivered in Dudley and the opportunities that it will bring for both patients and staff alike.

Executive Directors

Chris Weiner, Interim Medical Director

(In post May 2020 – March 2021)

Attendee of:

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

During 2020/21 Chris was responsible for the performance and standards including service user safety. He was the Trust's named Caldicott Guardian.

Chris has extensive experience across the health and care systems with 22 years with a background in Public Health. He has successfully transformed and driven improvement in health outcomes across public health, primary care, community and long-term condition services. His approach is outcome focused, evidence informed, data driven and developed with sustainable systems and processes in place.

Before his time at Dudley Integrated Health and Care NHS Trust, Chris worked as Associate Medical Director at NHSE/I for three years. Other experience has included working as a non-executive director in an acute trust, the interim provision of Director Public Health and Director of Adult Social Care and Clinical Director within a new start up community provider.

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

Appointed on 1st April 2020

Attendee of:

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

Caroline is responsible for the professional standards, education and development of nursing and allied health professionals and leads on clinical governance. She is also the Lead Executive responsible for service user and public engagement, safeguarding and infection, prevention and control.

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

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

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

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

Other Directors and persons attending Board regularly during 2020/21

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

Register of Interests

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

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

Board Effectiveness

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

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

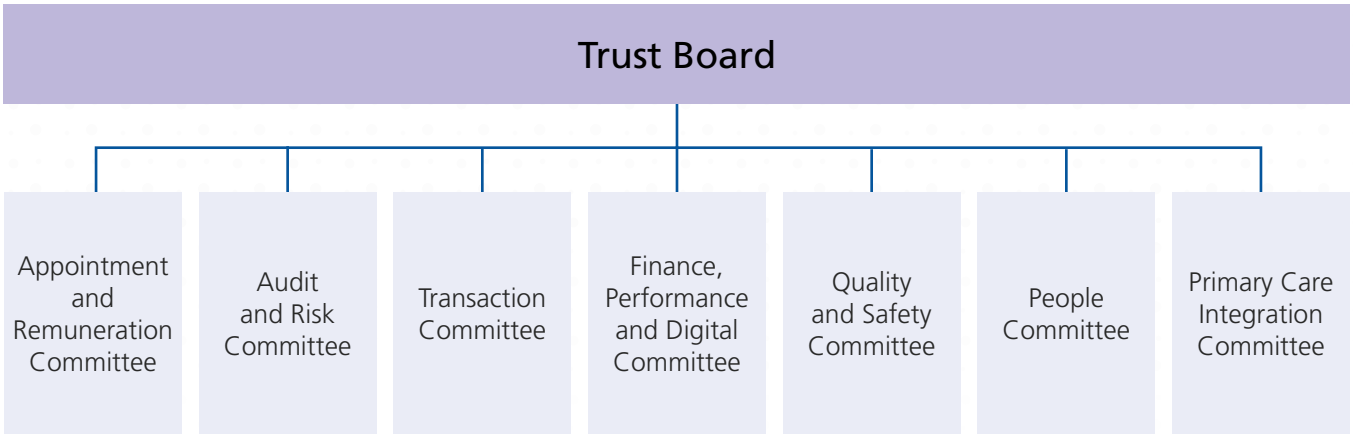
Individual Board members are appraised annually.

Board Assurance Committees

Trust Board Assurance Committees

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

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



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

Board Effectiveness Review

Trust Board Meetings

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

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

Report of the Audit and Risk Committee

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

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

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

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

The Committee's duties can be categorised as follows:

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

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

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

The committee self-assessment rating was strong.

External Audit Services

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

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

External Audit is required to review and report on:

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

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

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

Internal Audit Services

Our Internal Auditors during 2020/21 were CWAudit.

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

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

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

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

Committee Effectiveness and report of each of the Board Committees

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

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

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

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

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

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

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

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

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

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

Information governance incidents

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

Further information can be found within the Annual Governance Statement.

Attendance by members of Board Committees in 2020/21

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

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

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

The statement of Directors' responsibilities in respect of the accounts

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

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

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

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

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

By order of the Board

Signature .....Chief Executive

Date: 28th June 2021

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

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

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

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

Signed.....Chief Executive

Date: 28th June 2021

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

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

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

The system of internal control has been in place in Dudley Integrated Health and Care NHS Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

The integrated governance framework

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Capacity to handle risk

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

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

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

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

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

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

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

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

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

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

Trust wide arrangements which support robust assurance include:

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

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

The risk and control framework

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

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

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

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

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

This is achieved through:

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

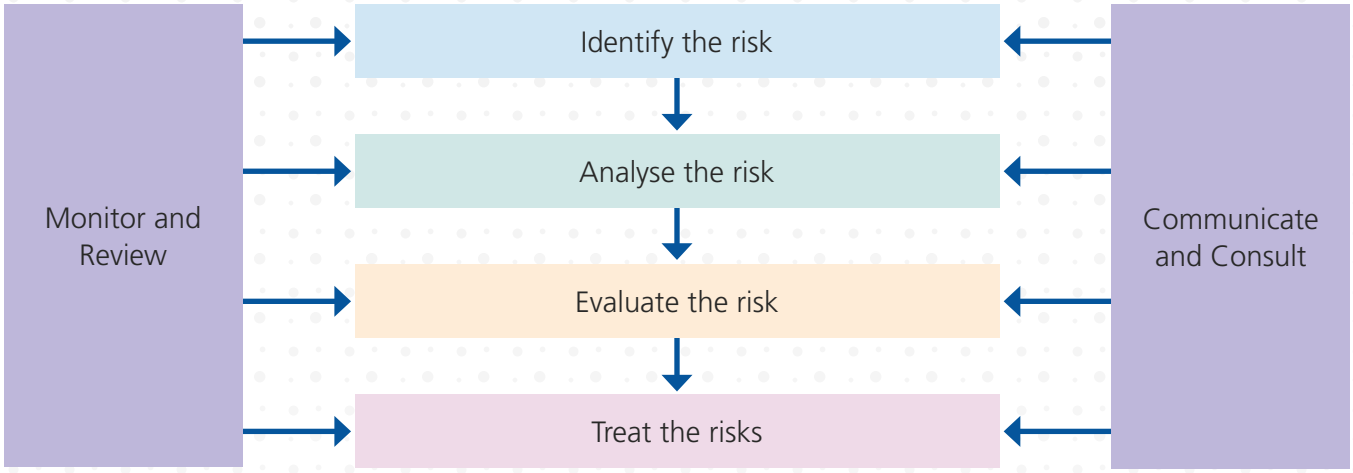
Fraud deterrence including the proactive work conducted by the Local Counter Fraud Service, supported by the 'Local Counter Fraud, Bribery and Corruption Policy'. Fraud deterrence is integral to the management of risk across the organisation especially as there could be clinical or health and safety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

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

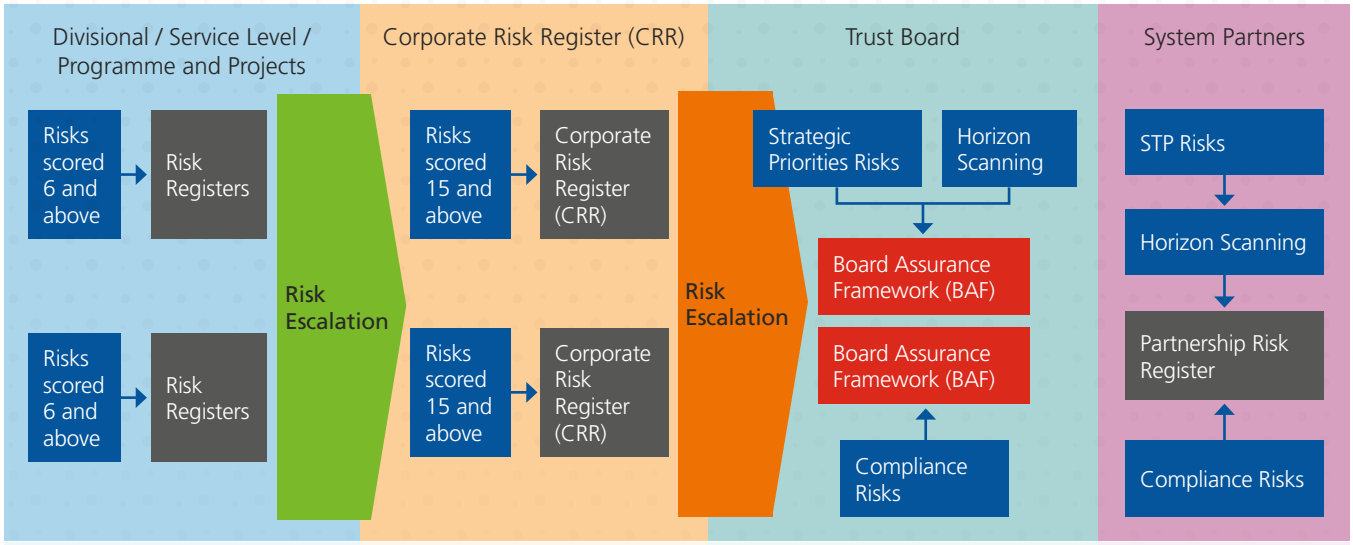
The Corporate Risk Register will be supported by the implementation of RLDatix module of risk management, the incident module has been implemented from 1st April 2021 and is now fully embedded and has provided the ability for real time reporting and escalation; it also aligns existing systems used for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

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

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



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



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

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

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

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

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

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

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

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

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

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

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

The Trust has undertaken sustainability impact assessments and has a Sustainability and Net Zero NHS Strategy in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with and has committed to delivery of a three year Green Plan by March 2022.

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

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

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

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

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

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

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

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

A financial plan approved and monitored by the Board.

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

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

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

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

Information governance

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

Data Security and Protection Toolkit

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

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

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

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

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

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

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

Cyber Security

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

Data quality and governance

In relation to data quality and management, the Trust:

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

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

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

Review of effectiveness

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

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

- A review of committee effectiveness and governance arrangements by the Trust Secretary and the committee recommendations, with the Board responsible for approving and monitoring systems to ensure proper governance and the management of risk which will be supported by an independent Well Led review in 2021/22.
- Reviews of key governance documentation such as Standing Orders, Standing Financial Instructions and Scheme of Delegation and the Board Assurance Framework.
- The oversight by the Audit & Risk Committee of the effectiveness of the Trust's systems for internal control, including the Board Assurance Framework (BAF). In discharging their duties the committee takes independent advice from the Trust's internal auditors (CWAudit) and external auditors (Grant Thornton). The BAF is also reviewed and challenged by the Board and updates are presented by the Trust Secretary.
- The internal audit plan to address areas of potential weakness in order that the Trust can benefit from insight and the implementation of best practice recommendations and the findings of relevant internal audits as it develops systems of internal control.

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

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

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

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

Conclusion

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

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

Signed.....Chief Executive

Date: 28th June 2021

Remuneration and Staff Report

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

Remuneration Report

Remuneration Policy

Our Chair is appraised on an annual basis by NHSEI.

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

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

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

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

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

Directors' Remuneration and Terms and Conditions

Senior Managers Remuneration

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

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

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

All Directors receive regular appraisals.

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

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

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

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

No termination payments have been made during the reporting period.

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

Remuneration report tables (Subject to Audit)

Single total figure table – 2020/21

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

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

- Dr Chris Weiner £145,000 - £150,000

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

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

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

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

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

Single total figure table – 2019/20

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

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

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

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

- Dr Mark Weaver £150,000 - £155,000

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

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

- Paul Lewis-Grundy, Company Secretary

Pension benefits – 2020/21 (Subject to Audit)

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

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

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

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

Cash Equivalent Transfer Values

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

Real Increase in CETV

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

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

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

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

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

Treatment of Pension Liabilities in the Accounts

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

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

Compensation for loss of office (Subject to Audit)

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

Payments to past directors (Subject to Audit)

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

Pay Multiples (Subject to Audit)

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

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

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

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

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

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

Staff Report

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

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

Band	Headcount No.
Senior Manager	5
Consultant	1
Total	6

Staff Numbers and Costs (Subject to Audit)

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

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

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

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

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

Staff Composition

Staff composition by gender

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

Staff composition by grade

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

Staff turnover

Staff turnover in 2020/21 was 9.14%.

Staff survey

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

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

Sickness absence data

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

Staff policies

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

Supporting staff with disabilities

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

Modern Slavery Statement 2020/21

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

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

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

Trade Union Facility Time Reporting Requirements

Relevant union officials

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

Percentage of time spent on facility time

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

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

Percentage of pay bill spent on facility time

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

Paid trade union activities

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

Expenditure on Consultancy

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

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

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

Off-payroll engagements

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

Off-payroll engagements longer than 6 months

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

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

New Off-payroll engagements

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

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

Off-payroll board members/senior official engagements

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

Exit Packages (Subject to Audit)

Reporting of compensation schemes – exit packages 2020/21

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

Reporting of compensation schemes – exit packages 2019/20

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

Exit packages: other (non-compulsory) departure payments

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

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

Report on the Audit of the Financial Statements

Opinion on financial statements

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

In our opinion, the financial statements:

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

Basis for opinion

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

Conclusions relating to going concern

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

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

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

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

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

Other information

The Directors are responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

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

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

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

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

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

Matters on which we are required to report by exception

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

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

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

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

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

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

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

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: **www.frc.org.uk/auditorsresponsibilities**. This description forms part of our auditor's report.

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

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

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

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

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

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

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

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

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

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

Responsibilities of the Accountable Officer

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

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

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

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

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

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

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

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

Use of our report

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

Signature:

Mark Stocks, Key Audit Partner

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

Date: 28th June 2021

Certificate on summarisation schedules

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

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

Finance Director Certificate

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

Matthew Gamage, Director of Finance

Date: 28th June 2021

Chief Executive Certificate

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

Paul Assinder, Chief Executiver

Date: 28th June 2021

NHS
Dudley Integrated Health and Care
NHS Trust

Annual accounts for the year ended

31 March 2021

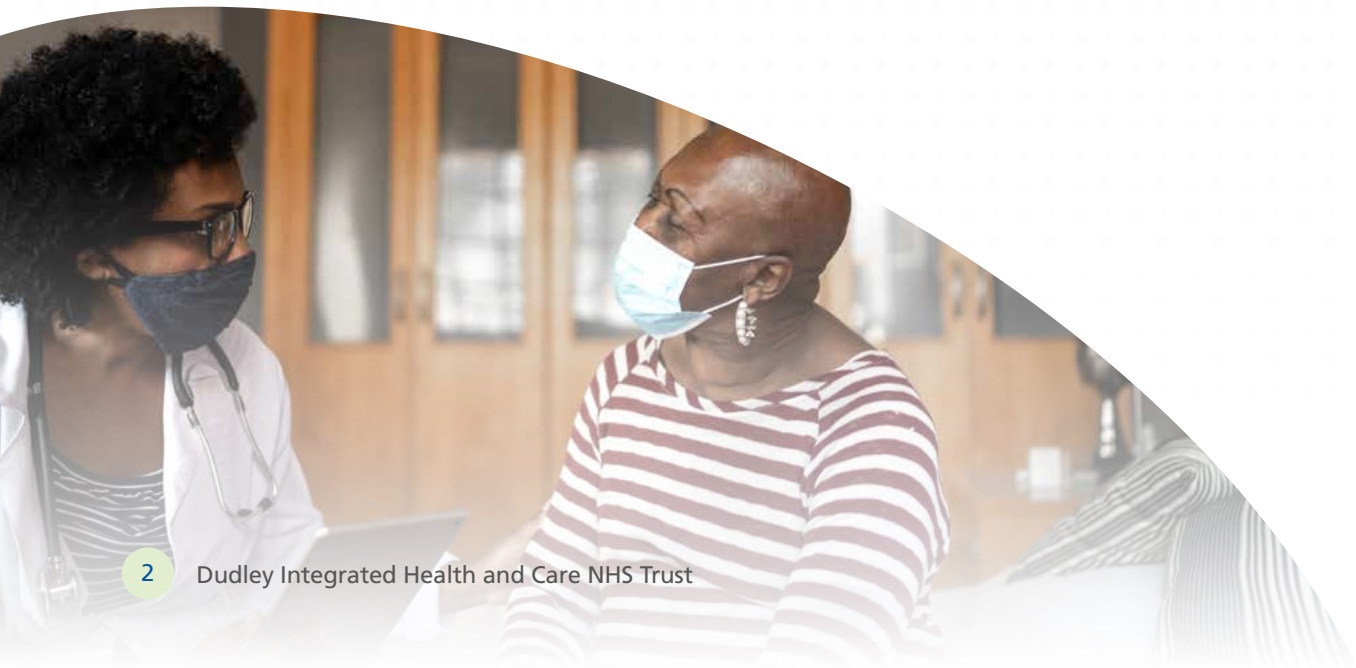
Statement of Comprehensive Income

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

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

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

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



Statement of Financial Position

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

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

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

Paul Assinder **Chief Executive Officer**

Date 28 June 2021

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

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

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

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

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Financial assets reserve

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

Merger reserve

This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve

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

Statement of Cash Flows

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

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

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

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

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

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

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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

Note 1.4 Other forms of income

Apprenticeship service income

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

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

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

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

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

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

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

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

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

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

Depreciation

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

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

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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

De-recognition

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

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Useful lives of property, plant and equipment

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

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

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

Note 1.8 Intangible assets

Recognition

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

Internally generated intangible assets

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

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

Software

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

Measurement

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

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

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

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

Amortisation

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

Note 1.9 Inventories

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

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

Note 1.10 Cash and cash equivalents

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

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

Note 1.11 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

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

Financial assets measured at fair value through other comprehensive income

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

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

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

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

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

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

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

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

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

Derecognition

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

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

Note 1.12 Provisions

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

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

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

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

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

Clinical negligence costs

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

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses

payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.13 Public dividend capital

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

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

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

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

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

Note 1.14 Value added tax

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

Note 1.15 Third party assets

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

Note 1.16 Transfers of functions to other NHS bodies

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

Note 1.17 Early adoption of standards, amendments and interpretations

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

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

IFRS 16 Leases

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

IFRS 16 changes the definition of a lease compared

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

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

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

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

Note 2 Operating Segments

Note Operating segments

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

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

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

Note 3 Operating income from patient care activities

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

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

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

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

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

Note 4 Other operating income

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

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

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

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

Note 5.2 Other auditor remuneration

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

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

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

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

Note 7.1 Retirements due to ill-health

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

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

Note 8 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6%, and the Scheme Regulations were amended accordingly.

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

Note 9 Operating leases

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

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

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

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

Note 10 Finance income

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

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

Note 11 Finance expenditure

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

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

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

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

Note 13.1 Property, plant and equipment - 2020/21

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

Note 13.2 Property, plant and equipment - 2019/20

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

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

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

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

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

Note 14 Inventories

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

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

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

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

Note 15.2 Allowances for credit losses

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

Note 15.3 Exposure to credit risk

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

Credit Loss Provision - Local Authority Contract Receivables

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

Credit Loss Provision - Other Non-NHS Contract Receivables

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

Credit Loss Provision - NHS Non Contract Receivables			
	Gross Amount	Lifetime Expected Loss Rate	Lifetime Expected Loss Allowance
	£000	%	£000
Days past due date			
Current	176	42.5	75
Total	**176**		**75**

Note 16.1 Cash and cash equivalents movements

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

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

Note 16.2 Third party assets held by the Trust

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

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

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

Note 18 Other liabilities

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

Note 19.1 Borrowings

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

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

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

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

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

Note 20.1 Provisions for liabilities and charges analysis

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

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

Note 20.2 Clinical negligence liabilities

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

Note 21 Contractual capital commitments

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

Note 22 Financial instruments

Note 22.1 Financial risk management

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

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

Currency risk

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

Interest rate risk

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

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

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

Credit risk

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

Liquidity risk

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

Note 22.2 Carrying values of financial assets

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

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

Note 22.3 Carrying values of financial liabilities

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

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

Note 22.4 Maturity of financial liabilities

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

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

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

Note 22.5 Fair values of financial assets and liabilities

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

Note 23 Losses and special payment

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

Note 24 Related parties

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

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

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

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

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

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

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

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

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

Note 25 Transfers by absorption

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

The resulting transfer by absorption is detailed below:

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

Note 26 Better Payment Practice code

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

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

Note 27 External financing limit

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

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

Note 28 Capital Resource Limit

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

Note 29 Breakeven duty financial performance

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

Note 30 Breakeven duty rolling assessment

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

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

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

If you would like this report in a different format or more information please email dihc.contactus@nhs.net

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Enclosure 17

Dudley Integrated Health and Care NHS Trust

DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST BOARD

TITLE OF REPORT:	**Quality Account**
PURPOSE OF REPORT:	To present the DIHC Quality Account report to the Board for approval
AUTHOR OF REPORT:	Jim Young – Associate Director of Quality & Governance Sue Nicholls – Director of Nursing, Quality & AHPs
DATE OF MEETING:	08 September 2021
KEY POINTS:	• All NHS Trusts are required to produce a Quality Account each year • For 2020/21, the deadline for formal submission to NHSE/I was June 30th 2021; no extension was offered as it was the previous year due to the pandemic • A draft version of this document, prior to final formatting, has been previously approved internally and submitted to NHSE/I by the required deadline. The draft report was also presented to the Health and Adult Social Care Scrutiny Committee on 16th June 2021
RECOMMENDATION:	That the Board formally approve this final version of the Trust Quality Account
ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:	None
ACTION REQUIRED:	Decision ☐
	Approval ☒
	Assurance ☐

NHS
Dudley Integrated Health and Care
NHS Trust

Quality Accounts

2020/21

Contents

About our Trust 4
Our Aim, Purpose and Commitments 5
What is a Quality Account? 7
Statement on Quality from the Chief Executive 8
Looking back on 2020/21 10
- Safe and Effective 14
- Incident reporting and management 14
- Safeguarding 16
- Medicines Management 18
- Preventing Infection 19
- Responding to Safety Alerts 21

Service User and Staff Experience 22
Looking forward to 2021/22 32
- Priorities for Improvement 32
- Safe and Effective 35
- Service User and Staff Experience 46

Statements of Assurance from the Board 52
- Review of Services 52
- Clinical Audit 54
- Clinical Research and Innovation 55
- Goals agreed with Commissioners 56
- Statements from the Care Quality Commission (CQC) 57
- Statement on relevance of Data Quality and our actions to improve Data Quality 58
- Reporting against Core Quality Indicators 2020/21 60

Core Quality Indicators – Incident Reporting… 60
Reporting against Local and other Quality Indicators 62
Engagement in the development of the quality account 63
Statement from Black Country and West Birmingham CCG 64
Statement from Dudley Metropolitan Borough Council Health and Adult Social Care Scrutiny Committee 66
Statement from Healthwatch Dudley 67
Statement of Director Responsibilities in respect of the Quality Account 2020/21 68
Glossary 69
How to provide feedback 74

About our Trust

Dudley Integrated Health and Care NHS Trust (DIHC) was formed in 2020 to provide an integrated care model in Dudley. The creation of the Trust is the output of a system partnership in Dudley who have collectively developed a model of care that integrates primary care with community services to provide the optimum opportunity for caring for as many people as possible in their home. We have completed our first year in existence, serving a Dudley population of just over 328,000 people.

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

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

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

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

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

Our Aim, Purpose and Commitments

01 Aim

- **Dudley first: community where possible, hospital where necessary.**
- **We are truly different. We are a new type of NHS organisation created to serve our Dudley population in a genuinely integrated way.**

02 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.**

03 Commitments

- **Put people first**

  We will:

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

- **Enable and support our staff**

  We will:

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

  We will:

  - Enable our staff to create and innovate.
  - Empower them with the skills and resources so they can improve and transform the services they provide.
  - Make this a priority freeing up their time to participate.
  - Make our services easy to navigate for patients, staff and citizens.
  - Work with our citizens to be the co-designers of future services.
- **Be accountable for our actions**
- Our job is to serve the people of Dudley and ultimately; they will judge our actions:
- Each of us has a personal responsibility for our decisions and actions; to be leaders. Only through our actions will we build trust and respect for the work we do.
- Be accessible and responsive - listen to our staff, service users and local population; actively seeking those whose voice is quieter than others or those that are 'hard to reach'; and then respond with the means available to us.
- We will behave inclusively, building on our diversity.
- We will encourage our population to be part of our future workforce and service suppliers.

What is a Quality Account?

All NHS Trusts are required to produce an annual Quality Account to provide information on the quality of the services they provide to the public. This requirement is defined in The Health Act (2009) and The National Health Service (Quality Accounts) Regulations (2010).

Dudley Integrated Health and Care NHS Trust (DIHC) welcomes this opportunity to be transparent and place information about the quality of our services into the public domain and for our approach to quality to be subject to scrutiny and debate.

The report provides a summary of our performance and our progress against the quality priorities we set last year and looks ahead to those we have set for the coming year. The report reflects the first year of operation as Dudley Integrated Health and Care NHS Trust.

The Trust routinely reports quality measures to both executive and board level. Data quality is assured through the Trust's data quality governance structures, with the Board of Directors confirming a statement of compliance with responsibilities in completing the Quality Report. However, there are a number of inherent limitations in the preparation of a Quality Report, which may impact on the reliability or accuracy of the data reported. These include:

- Data is derived from a number of different systems and processes, with only some of these being subject to external assurance, or included in internal audit programme of work
- Data is collected by a number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted
- As a newly-formed Trust, and in part due to the changes to data collection during the pandemic, not all data is available for our Trust via the usual national sources, such as NHS Digital. This is of particular relevance where the latest datasets are only available from prior to April 1st 2020. Where an alternative, internally sourced dataset exists that would help to provide relevant information this has been used and the source clearly indicated alongside the data itself.
- As a redesignated Trust, we have prepared this report as a continuation of Dudley and Walsall Mental Health Partnership NHS Trust, but have omitted any trend information from previous years as this information is not comparable to our current operations

The Director of Nursing, Quality and Allied Health Professional (AHPs) is the Trust's Executive lead, with responsibility for quality and the production of this report.

Our key stakeholders are given the opportunity to review and comment upon a draft of the Quality Report. The Trust's Audit Committee also reviews the draft report as part of its review of the Trust's Annual Report. The Board of Directors are responsible for final approval of the Quality Report.

All providers of NHS services are required to publish their Quality Report on the NHS website https://www.nhs.uk each June, summarising the quality of their services during the previous financial year.

Statement on Quality from the Chief Executive

Reflecting on the last year, which has also been our very first year as an NHS Trust, it has truly been an honour to work with colleagues who have shown tireless commitment in extraordinarily difficult times. They have also continued to recognise care and compassion as not only a foundation for high-quality care for our patients and service users, but also for how we treat and support each other to do the best we can.

We have had the opportunity to do some great things in our first year of existence, and have laid the foundations for our contribution to the population of Dudley to continue to expand and improve. Sadly, we are also mindful that the pandemic has claimed lives too and our thoughts are with every family who has lost a loved one over the past year.

Setting up a new NHS Trust during these unprecedented times has been challenging but despite those challenges and, in some instances, as a result of them I believe we have made a valuable and positive impact on the healthcare of people in Dudley and identified ourselves as an essential part of the local system.

Underpinning our approach to quality and safety, we have developed our 'Five Pillars of Quality' as a foundation for establishing our systems and processes for keeping people safe. This has included the development of our Quality & Safety Committee and robust reporting on key quality indicators from all of our services.

Whilst this first year has undoubtedly been focussed on creating and establishing the basic building blocks of good clinical governance, it has also been a time of continuous and rapid development.

Starting with our two mental health services - the local Dudley IAPT ('Talking Therapies') and Primary Care Mental Health team – inherited from Dudley and Walsall Mental Health Partnership Trust, we embarked on a number of service transfers into our organisation which has seen us quadruple in size over our first 12 months.

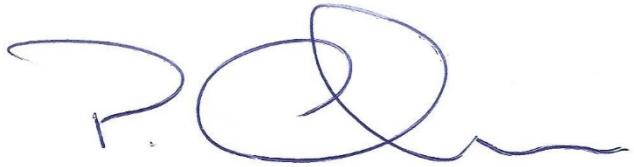
These transfers of clinical services including our GP practice, High Oak Surgery, have been based on a principle of 'safe landing'; putting the continuity of service and quality at the forefront of any change. This has enabled us to successfully bring a number of services under one roof and establish processes that will support future service transfers.

Our initial Quality Priorities reflect the balance between the groundwork for a new organisation and continuous development in an ever-changing landscape of healthcare and the ongoing pandemic.

Building on these foundations, we are now looking forward to firmly embedding our safe ways of working, learning from our first 12 months in existence and planning for further development over the next 12 months.

This Quality Account provides information on progress against key priorities and sets out plans for the upcoming year.

To the best of my knowledge, the information contained within this Quality Account is accurate.



Paul Assinder

Chief Executive

29th June 2021

Looking back on 2020/21

This part of the report typically reviews the priorities for quality improvement identified in last year's report. As this is of our first year as an NHS Provider Trust, this will include a small number of specific quality priorities which we identified for this year but as part of a wider look at how we have managed quality and its improvement in the first 12 months. This reflects us having been working to a comprehensive development plan that balanced us building the foundations for a safe and effective organisation alongside continuously changing and growing.

With respect to building our foundations for quality and safety, we have underpinned this by defining five 'pillars' or domains of quality which reflect the basics of providing good quality care with the reality of starting and developing an organisation for the future. For the purposes of this document, our emphasis is primarily on the first three pillars although these are supported by robust financial and resource management as key elements of maintaining good systems going forward.

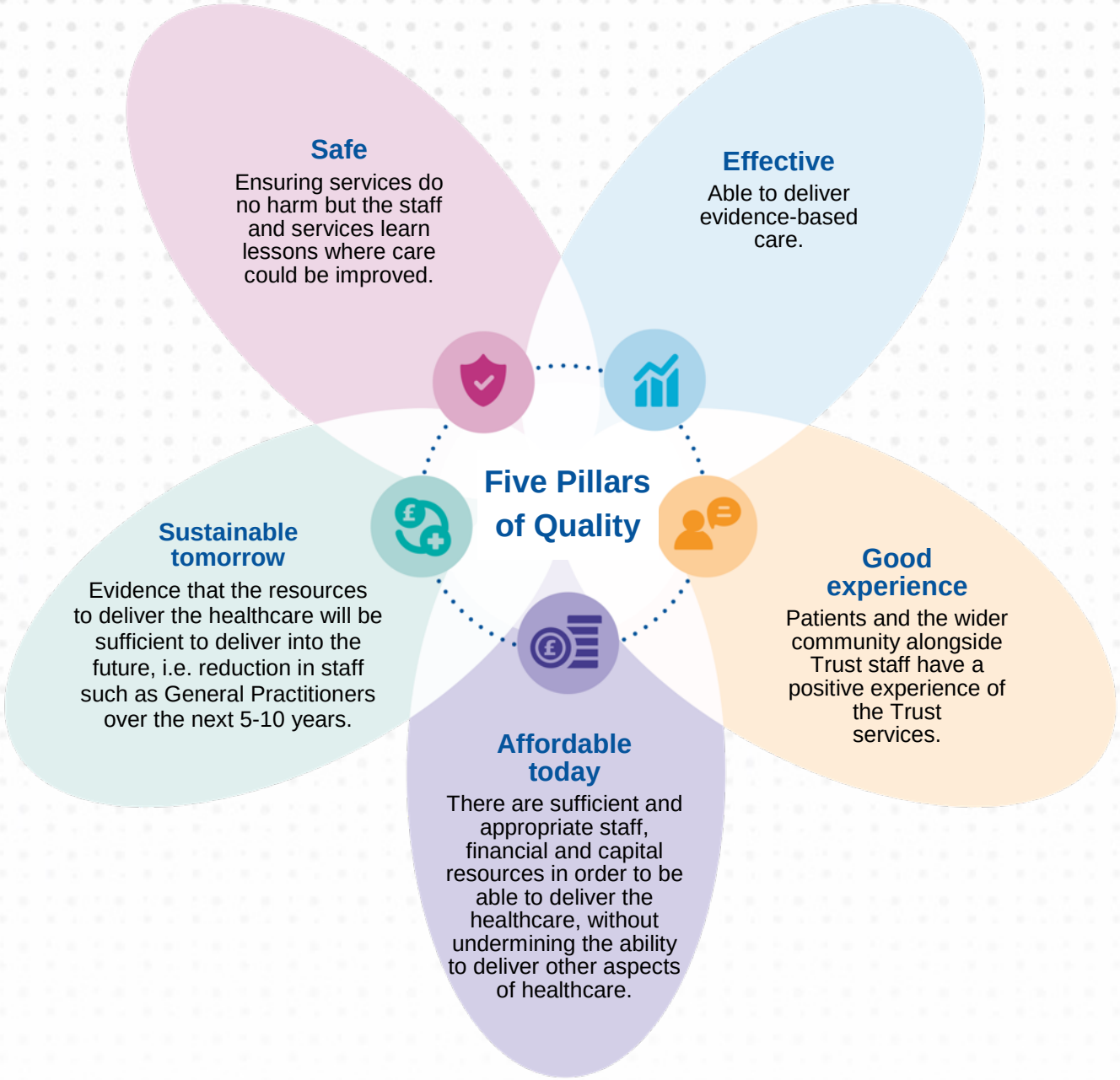


***Figure 1**:'Five Pillars of Quality'*

During this first year, our internal governance arrangements have been developed to ensure robust monitoring and assurance reporting through the organisation from service-level to the Board, and a 'joined-up' approach to corporate and clinical governance.

The establishment of our Quality and Safety Committee has been key to this, set up to monitor, review and report to the Board on the quality of care to the Trust's patients, specifically in relation to patient safety, clinical effectiveness and patient experience.
This past 12 months has also seen a gradual expansion in the clinical services we provide, each of which has informed and shaped our approach to quality and the opportunities for improvement:

From 1st April 2020	From 1st October 2020	During the last 3 - 6 months of 2020/21
• Dudley Talking Therapies (IAPT) • Primary Care Mental Health • Pensnett Respiratory Assessment Centre	• High Oak Surgery • Intermediate Care and Continuing Healthcare • Pharmaceutical Public Health	• Primary Care Network (PCN) services • *Preparation for Dudley School Nursing (transferred 1st April 2021)*

Quality Priorities

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

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

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

Commitment to learning

DIHC has established systems and processes to focus on encouraging and supporting clinical and operational staff to reflect to 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.

Safe and Effective

Incident reporting and management

During 2020/21, the Trust has established a robust incident management process ensuring that all potential or actual incidents relating to patient safety are reported and appropriately reviewed or investigated.

As a consequence of the 'safe landing' principle of transferring services into the Trust, this has required the collation of incident information from a variety of sources until the implementation of a single system.

A total of 91 patient safety incidents were reported during 2020/21 with only one of these meeting the criteria for reporting as a Serious Incident (SI). As with all SIs, this incident has been subject to robust investigation with the focus being on identifying any opportunities for learning that could help to reduce the likelihood of recurrence and prevent further harm to service users.

No Never Events have been reported during 2020/21.

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
SIs	0	0	0	0	0	0	0	0	0	0	1	0
All Incidents	5	5	5	7	11	7	15	14	8	6	7	1

Table 1: *Reported Incidents 2020/21*

The Trust has also identified the Associate Director of Governance and Quality and the Deputy Director of Nursing as the Trust's Patient Safety Specialists to provide a robust blend of clinical and non-clinical expertise and to ensure resilience. These individuals will lead on the development of the Trust Patient Safety Strategy in line with the National Patient Safety Strategy.

Quality Priority: Implementation of RLDatix

Why is this a priority for improvement?	How has quality been improved?
DIHC places emphasis on being a learning organisation to drive improved experiences for staff and patients. The Trust will continuously improve patient safety and will support a clinical governance infrastructure that is responsive and supportive. To enable this within DIHC a patient safety reporting database is necessary. RLDatix is a bespoke web-based software product that provides functionality across a number of areas of clinical governance.	Following a procurement exercise RLDatix was commissioned and went live on 1st April, providing functionality initially for managing incidents and service user feedback with risks and safety alerts to follow early in 2021/22. A significant amount of work has taken place during 2020/21 which has engaged staff across a number of services in developing and configuring the system. A training plan has been developed. The RLDatix system will be a key building block of DIHC's patient safety strategy and further strengthen the established patient safety reporting to the Quality and Safety Committee and the wider Trust.

Safeguarding

It is Dudley Integrated Health and Care NHS Trust's statutory responsibility to ensure that the services that it delivers and commissions provide a safe system that safeguards vulnerable children, young people and adults. The Trust's Safeguarding Children, Young People and Adults Safeguarding Strategy sets out the strategic aims and priorities in relation to safeguarding children, young people and adults at risk of abuse or neglect which reflects the overall vision, strategy and objectives of DIHC.

The Government reforms of the NHS put patients and the quality of their care at the heart of the NHS. The Government's commitment to patient choice, control and accountability includes support and protection for those in the most vulnerable situations.

Dudley Integrated Health and Care NHS Trust is responsible for fulfilling safeguarding responsibilities for people who come into contact with its services either directly or indirectly. It does this by having arrangements in place to ensure that Vulnerable Children and Adults with Care and Support needs are safeguarded from harm.
The Trust has statutory duties under the Children Act 2004 & Care Act 2014 and is a member of the partnership arrangements through the Dudley Safeguarding People Partnership Board (DSPPB). This means we work in partnership with the local authority and other partners to fulfil their safeguarding responsibilities.

The organisation is represented on DSPPB sub groups, Domestic Abuse Forums and all of their respective sub groups to ensure comprehensive partnership working is in place to protect our communities.

The development of the Safeguarding infrastructure across the life-course was one of the Trust's key quality priorities during 2020/21 – work undertaken included:

- A review of mandatory training requirements to inform our training strategy and safeguarding training passport
- Development of a one year safeguarding strategy and work plan to further embed structures and processes
- Implementation of RLDatix for safeguarding reporting and review
- Policy development
- Review of safeguarding supervision and development of a safeguarding supervision policy

Quality Priority: Develop the Trust's safeguarding infrastructure 'across the life course'

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

Medicines Management

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

The Dudley Prescribing Ordering Direct (POD) Teams have continued to provide great support to local GP practices during the year. Monitoring medication incidents reported through the RLDatix system is a key role of the team. During 2021 there was a focus on collaborative work with Dudley Group NHS Foundation Trust around communication of medicine changes post discharge from hospital.

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

Preventing Infection

Infection prevention and control (IPC) is fundamental in improving the safety and quality of care provided to patients. Healthcare Associated Infection (HCAI) can cause significant harm to those infected. The term Health Care Associated Infections encompasses any infection by any infectious agent acquired as a consequence of a person's treatment by the NHS, or which is acquired by a health care worker in the course of their duties.' *The Health Act (Department of Health, 2006)*

All Trusts are required to have a Director for Infection Prevention and Control (DIPC). This position is held by the Executive Director of Nursing, Quality and Allied Health Professionals. The DIPC leads the infection prevention and control agenda and reports to the Trust Board and Quality and Safety Committee on the delivery of the annual programme of work. While the risk of infection is small, remaining vigilant to reduce the risk of infection is essential.

During the past year, the NHS was met with the unprecedented challenge of COVID-19 at the time that Dudley Integrated Health and Care Trust was incepted. This led to a further enhanced focus on infection prevention and control to ensure our staff, patients and service users were safe; this included staff being supported to work from home where practical to do so, undergoing regular individual risk assessments and accessing lateral flow testing in line with Government policy. The Trust also played a role in supporting the local system response to COVID-19.

During 2020/21, the Trust has had no instances of any of the routinely monitored 'alert' organisms, bacteria which are responsible for difficult to treat infections e.g. MRSA, MSSA and E.coli bacteraemia and Clostridium difficile.

Key updates from 2020/21

- Mandatory training compliance has remained a focus, particularly with different groups of staff transferring into the Trust at various times during the year
- Staff have been actively supported to access flu and COVID-19 vaccinations; generally good compliance for frontline staff but with the recognition that this could be further improved with work already underway to identify improvements
- Working with our public health colleagues, the Trust also supported the local system to implement a vaccination programme for care home staff and patients

Focus for 2021/22

The Trust will continue to develop its annual infection prevention work programme which will include the following:

- Review and strengthen the IPC specialist advice and support available to the Trust
- Increase training compliance
- Review IPC policies and procedure

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

Responding to Safety Alerts

Patient safety alerts are issued by NHS England/Improvement (NHSE/I) to notify the healthcare system of risks and provide guidance on preventing incidents that may lead to harm or death.

Due to the nature of our services, many alerts are often not applicable to the Trust but all alerts are reviewed to ensure all relevant actions are taken. Executive oversight of any required action plans and their implementation is currently managed via the Clinical Quality Oversight Review Group.

At the time of writing this report, all alerts had been responded to within the required timescales.

Looking to 2021/22, the Trust is committed to the following:

- Strengthening the process through the use of a dedicated system as part of RLDatix implementation
- Develop robust processes for audit and monitoring of implementation of safety alerts

Service User and Staff Experience

Involving and listening to our service users

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 through listening to peoples' experiences and views, responding comprehensively to feedback and demonstrating what has been improved as a result.

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

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

Complaints Management

The Trust recognises the value in listening to feedback from our service users, including complaints, and we are committed to providing an accessible complaints process and a robust and transparent process for investigating and learning from complaints.
A total of 15 formal complaints were received by the Trust during 2020/21; none of these have been referred to the Parliamentary Health Service Ombudsman.

Although no obvious themes have been identified from the small number of complaints, a number were related to the perceived attitude of the staff involved, largely with services being provided via remote consultations. This is being reflected on as part of planning for more face-to-face work alongside continuing remote sessions.

The Trust also received 13 compliments relating to both our mental health services and the Pensnett Respiratory Assessment Centre.

Friends and Family Test (FFT)

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 Services

In 2020/21, 112 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. A summary of those responses is shown in Table 2 below.

The majority of the responses were extremely positive; only one response in Quarter 1 was answered as 'neither good nor poor' and related to the administration around the appointment booking process with the actual clinical treatment being stated as 'brilliant'. Other comments also referenced the excellent treatment they felt they had received, how our staff had been caring and listened to them and how they felt better able to cope themselves having been given the tools to do so.

Q1	Q2	Q3	Q4
92%	100%	100%	100%

***Table 2**: Mental Health Services - % FFT responses of 'Good' or 'Very good'*

High Oak Surgery

The FFT for patients of our GP practice is based on giving a score on a range from 'extremely likely' to 'extremely unlikely' to recommend the service, sent out to patients via text message. A summary of responses is provided in Table 3 below.
In 2020/21, from when the practice transferred into DIHC on October 1st, 438 patients responded to the High Oak Surgery Friends and Family test.

Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
91%	96%	92%	94%	100%	95%

***Table 3**: High Oak Surgery - % FFT responses of 'Likely' or 'Extremely likely' to recommend*

Involving our Partners and Stakeholders

We continue to focus on developing meaningful relationships with our wider stakeholders ensuring they are kept up to date with Trust developments and providing them the opportunity to influence the delivery of services through two-way communications and engagement.
Over the coming year there will be a continued focus on strengthening partnership working. Central to the management of our relationship with our stakeholders is the development of our integrated care model.

Key engagement activities in 2020/21 are outlined on the table opposite and include:

Commissioners	Service users and the community
• Attended local Mental Health Programme Boards • Attendance at Sustainability and Transformation Partnership/Integrated Care Systems meetings • Development of the Integrated Care Provider contract and implementation of the model of care • Participated in monthly Contract and Quality Review Meetings • Worked in partnership to develop services and pathways and address gaps and inconsistencies in service provision • Worked closely with CCG communications teams to support local initiatives such COVID-19 response, winter campaign, long term plans and place-based care	• Over 40 opportunities for engagement and information shared with local people, communities and wider stakeholders • Regular meetings with the public through the Healthcare Forum and the Patient Opportunity Panel – representative of Patient Participation Groups • Supported some campaigns throughout the year such as Mental Health Awareness Week

GPs	Local NHS providers, public sector / third sector organisations	Media
• Engagement with GPs and commissioners on the development of place based models of care in Dudley • Clinicians attend regular forums providing education and input to GP Forums • Fortnightly meetings with Primary Care Network (PCN) Clinical Directors. • PCN Clinical Director attendance at monthly Primary Care Integration Committee • Maintained communication through the fortnightly Practice Bulletin and monthly engagement events	• Throughout 2020/21 we have worked closely with our NHS Provider partners to respond to COVID-19 and to continue to develop integrated pathways and developing the model of care in Dudley • We work with our NHS, council, voluntary sector and Healthwatch colleagues on the Dudley Partnership Board to develop services for patients. We have particularly focussed on how we develop our collective services for our children and young people. • We have an excellent relationship with Dudley Council for the Voluntary Sector and continue to develop our social prescribing services with Integrated Plus.	• Continued to develop relationships with local media responding to enquiries and proactively promoting news • Concentrated on building our regional profile including items on BBC Midlands Today, local radio stations and newspaper articles. Continued to develop relationships with local media responding to enquiries and proactively promoting news • Built on our national, regional and local profile

Quality Priority: Capture the patient experience of using the Pensnett Respiratory Assessment Centre	
Why is this a priority for improvement?	**How has quality been improved?**
The NHS faced an unprecedented challenge during 2020/21 due to the coronavirus pandemic. As a result GP led 'red-sites' were implemented to provide a place to see patients with coronavirus symptoms face to face. Dudley's 'red-site' was the Pensnett Respiratory Assessment Centre. Primary care had to rapidly develop a triage model of care with the ability to review face to face those individuals with symptoms of COVID-19. In addition the centre was responsible for treating patients across the borough of Dudley working to a very different model which included remote monitoring.	Our survey of the Pensnett Respiratory Assessment Centre was incredibly positive. 90% of respondents said they were satisfied with the service they received. A large majority of respondents (94%) had no problems finding the centre and felt the instructions they received for attending an appointment were good while 97% said they were well advised on what to do when arriving at the centre.

Involving and listening to our workforce

At 31st March 2021, we employed 221 staff from across a broad spectrum of specialisms and backgrounds. Some of these staff were previously employed by Dudley and Walsall Mental Health Partnership NHS Trust, whilst others transferred in to DIHC on 1st October 2020 from Dudley CCG or from the private company which previously ran High Oak Surgery. We made every effort to welcome and support every member of transferring staff through a programme of cultural integration both pre, during and post transfer.

We support a culture that is based upon working openly and collaboratively to provide high quality services that put the experience of our service users at the heart of all that we do.

The majority of our employees are clinicians and "front-line" staff. They are our most important resource and without their dedication, we would not be able to provide the services that we do.
Communication is central to every organisation. When used effectively it supports the creation of a positive working environment, cements working relationships with internal and external stakeholders and sets the tone for the entire organisation.

We recognise that building a culture of two-way communication, is crucial in helping to ensure that staff feel recognised and valued. In order to develop and maintain effective communications, the Trust promote a culture that:

- Is open, transparent and clear
- Encourages staff to suggest new ways of working
- Supports constructive feedback

Throughout 2020/21 we continued to strengthen how we communicate and engage with staff which has increased involvement and positive feeling amongst colleagues. We have established our Freedom to Speak Up guardians to support our staff in raising concerns and have staff side representatives who meet regularly with our People directorate.

We have built our social media presence producing more content and creating a closed staff Facebook group preparing for the enlarged Trust where we post regular updates and other relevant content for existing staff and those about to transfer in.

Staff Survey

Only two of our teams – a total of 38 responses - were able to participate in the National Staff Survey during 2020, under the remit of the Black Country Healthcare NHS Foundation Trust survey.

We do not have comparative data from previous years due to the organisational changes.

The staff survey themes are scored out of 10 and the scores for the DIHC teams that took part are in the table below.

Whilst some clear areas for improvement can be seen, overall the results are positive and the work currently being undertaken around culture and engagement within the Trust will aim to address the areas for improvement and we would hope to see improvements in our 2021 survey scores.

Equality Diversity and Inclusion	Health & Wellbeing	Immediate Managers	Morale	Quality of Care	Safe Environment – Bullying & Harassment	Safe Environment - Violence	Safety Culture	Staff Engagement	Team Working
9.0	6.4	7.3	6.3	7.6	8.2	9.4	6.9	7.1	6.8

***Table 4**: National Staff survey results*

To supplement the national survey, we also undertook our own survey – all responses were above 75% positive, and some highlights are:

- 83% of staff feel welcomed and part of the team by DIHC
- 78% of staff feel communication is effective
- 82% of staff feel their voice is heard
- 88% of staff feel their health and wellbeing is important to DIHC
- 95% of staff feel trusted to do their job
- 78% of staff would recommend DIHC as a place to work
- 84% of staff are looking forward to continuing in their work with DIHC

"You said, we did"

In response to the staff survey, a number of areas of development are now in progress aligned to the areas staff want to see improved:

Staff Health & Wellbeing Plans including new Employee Assistance Programme and benefits platform for DIHC staff	**Developing a Just and Learning Culture for staff to feel safe, as well as a leadership development framework**	**Redesigning some of our policies and processes, including our own NHS jobs platform and recruitment process map**
Updating and developing the Welcome Pack, Local Induction and Onboarding Guidance to support new staff to DIHC to navigate more easily	**Development of our Equality, Diversity and Inclusion Objectives and setting up staff networks and Inclusion Champions, as well as anti-racism training**	**Developing systems for staff to get more involved in service redesign, quality improvement and engagement**

***Figure2**: "You said, we did" – actions taken in response to the staff survey*

Impact of COVID-19 on our staff

Staff have responded swiftly and positively to the emerging situation, ensuring that they followed guidance and provided access to patient care through a process of risk assessment. Service staff who maintained face to face contact have adapted to enhanced infection prevention and control processes. Many other staff have needed to work from home, and some have experienced isolation.

We have offered our staff access to emotional and psychological support during this challenging time, recognising that their experiences both professional and personal have placed significant pressure on their health and wellbeing. We have also supported our staff in adopting enhanced flexible and home working arrangements.

Equality, Diversity and Inclusion Summary

The Office of National Statistics records show the Dudley total population standing at 312,925, of which 20% are aged 30 to 44, and 63,428 (20%) have limiting long-term conditions. Around 11% of the population are from Black, Asian and Minority Ethnic (BAME) backgrounds. The Learning Disabilities (LD) Outpatient & Community services have supported 3,000 people of which the average age is 35 to 42. There are more males compared to females in LD services. Around 9% of people using LD services in Dudley come from BAME backgrounds. We also have Children, Young People and Families Services in Dudley.

We are committed to supporting the Equality Delivery System (EDS) to support NHS commissioners and providers to deliver better outcomes for patients and communities. It also aims to deliver more personal, fairer and more diverse working environments for staff. The EDS is all about making positive differences to healthy living and working lives.

We will produce our first Annual Equality and Diversity Report, have established an Equality and Diversity committee, chaired by the Chief Executive, and set up an Inclusion, Anti-racism and Allyship staff network.

Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES)

The WRES and WDES are mandated for NHS Trusts.
Whilst DIHC has not been required to formally undertake a WRES or WDES assessment in this period, we have actively worked to ensure that we are an organisation that supports race and disability equality.

We are a Disability Confident employer, and have established our Anti-Racism campaign. We have also undertaken improvements in our recruitment processes and training for managers to ensure fairness and transparency.

We are committed to a culture where those working for us are valued and appreciated for the skills and talents they bring and where the needs of those using our services are understood and respected.
We are committed to treating everyone who visits or works for us with respect and as individuals, taking into account their individual differences, personal values and perspectives.

Our successes and achievements

The Trust has successfully completed the following actions to meet its Public Sector Equality Duty (PSED) compliance:

- Equality Delivery System (EDS) and Equality Objectives – The Trust continues to progress with the EDS2 implementation action

plan and has successfully achieved progress against the Trust's four equality objectives.

- Accessible Information Standard (AIS) – Working towards ensuring our data and information is accessible.
- Equality Impact Analysis Assessments (EqIAs) – Developed the framework for EqIAs for policies, procedures and service development areas.
- Developed the Trust EDI committee.
- Developed a staff network.
- Became a Disability Confident Employer.

Quality Priority: Develop the Equality Diversity and Inclusion Work programme	
Why is this a priority for improvement?	**How has quality been improved?**
Diversity and Inclusion in the workforce leads to improved health and greater staff and patient experiences of the NHS. A diverse workforce enables the Trust to deliver a more inclusive service and improved patient care. The Trust wants to ensure that its workforce represents the community we serve and to recognise and value differences through inclusion and enable DIHC to shape the future of healthcare and its workforce through becoming a more inclusive employer.	The Trust has implemented an Equality Diversity and Inclusion Committee chaired by the Chief Executive. This demonstrates the significant emphasis the Board are placing on this agenda. An objectives and inclusion plan has been developed (2020-2022) comprising of four key workstreams; • Recruitment and selection • Developing data and evidence • Communication and engagement • Education Guidance on writing job descriptions and person specifications that avoid discrimination and bias has been developed as has a process and guidance on values and competency-based recruitment. The Board has endorsed the Trust's anti-racism campaign.

Looking forward to 2021/22

Priorities for Improvement

Our focus during 2021/22 will be to continue on our development journey as an Integrated Care Provider, to develop our own services, support the restoration of local place services, and to work collaboratively with local system partners to implement an integrated care partnership in Dudley. To support these ambitions, we have developed ten strategic objectives for 2021/22:

Award of the ICP contract to DIHC	**Integrate and develop existing services**	**Ensure the safe and smooth transfer of services by 1st April 2022**	**Develop and deliver the DIHC Organisational Development Strategy**	**Be a learning organisation that is rooted in the heart of the local community**
Development of the working partnership between DIHC and Primary Care	**Work with system partners to restore services effectively**	**Develop DIHC as lead provider in the place based integrated care partnership**	**Demonstrate effective use of resources and be a sustainable organisation**	**Develop the full Integration Strategy for Primary Care**

Quality Priorities

Following on from the initial priority work defined and developed during 2020/21, an exercise was undertaken to identify a number of focussed developments or priorities that would contribute to our overall quality improvement plans for 2021/22. The specific quality priorities were identified as follows:

- Reflection on progress in 2020/21 and any requirement for further development of previous priorities
- Reflection and learning from 2020/21 to identify additional opportunities

- Discussion with service leads

This exercise identified 14 quality priorities, categorised under five key headings:

1. Developing service user and staff engagement & feedback
2. Integrated primary care and community pathway development
3. Underpinning clinical systems and processes
4. Protecting and supporting vulnerable people
5. Inclusivity and equitable access

These quality priorities represent the next phase of our short-term developments alongside the development of our overarching Patient Safety Strategy

Priority (*italics* indicates rolled over from 20/21)	**Services involved** (Lead service)	**Quality domain**
Development of RLDatix reporting system	*All (Clinical Governance)*	*Underpinning clinical systems and processes*
Development of EMIS for School Nursing Service	School Nursing Team	Underpinning clinical systems and processes
Develop a robust Learning & Development strategy	Corporate – HR, Nursing and Medical Directors	Underpinning clinical systems and processes
Ensure that staff are competent and confident to apply the most appropriate legal frameworks regarding Safeguarding	*Corporate - Safeguarding*	*Protecting and supporting vulnerable people*
Establish a community Learning Disability Wellbeing Service	Primary Care Development	Protecting and supporting vulnerable people

Priority (*italics* indicates rolled over from 20/21)	Services involved (Lead service)	Quality domain
Development of a homelessness pathway and outreach service	Primary Care Development	Protecting and supporting vulnerable people
Further roll out and expansion of the first contact musculoskeletal (MSK) practitioner	Primary Care Development	Integrated primary care and community pathway development
Establish a community based MSK /Pain clinic	Primary Care Development	Integrated primary care and community pathway development
Promote a person centred approach to safe and effective medicines use	Medicines Management	Integrated primary care and community pathway development
Deliver the Equality Diversity and Inclusion Work programme	*All (HR)*	*Inclusivity and equitable access*
To improve access to the IAPT service	Dudley Talking Therapies Service	Inclusivity and equitable access
Development of service promotion	All (Corporate – Communications)	Developing service user and staff engagement & feedback
Development of a standardised patient reported experience measure (PREM)	Intermediate Care Team	Developing service user and staff engagement & feedback
Undertake a service expectation / feedback questionnaire for schools	School Nursing Team	Developing service user and staff engagement & feedback

***Table 5**: Summary of 2021/22 quality priorities*

Safe and Effective

Quality and Safety Strategy

Dudley Integrated Health and Care NHS Trust is committed to developing a robust and meaningful Patient Safety Strategy as the basis for its future quality improvement and development. This will encompass a number of key elements:

- **Alignment with the National Patient Safety Strategy** – led by our nominated Patient Safety Specialists we will ensure that we are aligned with the developing work around the National Patient Safety Strategy. This will include supporting any required changes around incident reporting and investigation as well as embedding the right cultures around maintaining and further developing our open reporting approach. This will cover both training and education as well as practical systems and processes to support what we do.

- **Learning through better use of data** – through the development of our Business Intelligence function, we will implement better data analysis systems and tools to support valuable learning from incidents and feedback, including theme and trend analysis

- **Restorative Just Culture** – in support of the above, DIHC is working towards a culture focused on restoration and learning from incidents or untoward events. This approach aims to avoid punitive or retributive action and instead works to take learning and improvement forward and avoid further harm to any of the individuals involved. We believe this will make us a safer, more transparent, and innovative organisation, that puts patient and staff welfare right at our heart. Our approach is based on the nationally recognised programme developed by Mersey Care which has developed a culture of learning rather than punitive blame. The programme encourages leaders across the organisation to focus on learning from events and embraces a truly “no blame” culture. DIHC has commissioned this as a leadership programme for all leaders across the organisation. The first cohort is planned for early 2021/22 with a second cohort already planned for October 2021.

- **Further development of RLDatix** – following the initial implementation of our incident and service user feedback management system [Phase 1 was successfully implemented on 1st April 2021 as planned], further phases of implementation and associated training will further enhance our systems of reporting and monitoring quality. This will include improved systems for managing safety alerts together with embedding robust risk management at the service level to complement and further improve the existing risk management systems already in place in the Trust.

Quality Priority: Development of RLDatix Reporting system		
Service(s):	**Priority area**	**Quality domain**
All	Underpinning clinical systems and processes	• Safe • Effective • Good experience • Sustainable tomorrow
Why is it a priority?	**How will quality be improved?**	**Quality objectives**
• Robust reporting and management systems are essential for core clinical governance processes including incidents and feedback • RLDatix provides the platform for these processes and the opportunity for other aspects of clinical governance not yet developed	• RLDatix implementation will continue to include safety alerts and risk management • Further enhancements will be made to existing incident and feedback functionality • Where appropriate, additional uses of existing functionality will be developed to improve existing clinical governance processes • Specific review and development of safeguarding functionality • More effective learning	• Improved incident and feedback management • Improvement of wider clinical governance processes • Improved learning

Safeguarding

Safeguarding remains a priority for 21/22 as the Trust further develops its clinical services and continues to embed our systems and processes in order to discharge our statutory duties in terms of safeguarding children and adults.

Quality Priority: Ensure that all staff are competent and confident to apply the most appropriate legal frameworks regarding Safeguarding		
Service(s):	**Priority area**	**Quality domain**
All	Protecting and supporting vulnerable people	• Safe • Effective • Sustainable tomorrow
Why is it a priority?	**How will quality be improved?**	**Quality objectives**
• There is a need for services to understand and be able to apply the most appropriate legal frameworks in each situation including the Mental Capacity Act and Community Deprivation of Liberty Safeguards (CDoLs) • Ensuring the organisation is prepared for the introduction of Liberty Protection Safeguards (LPS) including 16-17 year olds	• Staff will feel confident to apply the relevant safeguards in accordance with the appropriate legal framework • Decisions and assessments are clearly documented to demonstrate best interest discussions	• Establish Safeguarding Committee • To undertake a safeguarding training needs analysis • To identify and review all individuals who require a CDOLs • To ensure all individuals who require a CDOLs application has one with a review mechanism • To provide training and development in CDOLs

Medicines Management

In 2021-22 the Pharmaceutical Public Health team will be establishing cutting edge practice to support the delivery of services to Dudley GP practices and Primary Care Networks. Specifically, there will be a focus on shifting our work focus away from products and conditions to that of supporting patients. The Structured Medication Review (SMR) will be the main activity for improving safety and effectiveness of prescribed medicines, with audit programmes being incorporated into this activity rather than as stand-alone activities. The team will be designing surveillance systems to ensure patients are monitored and reviewed, working towards a 'system accountability' rather than relying on individuals to safety net at the prescription signing stage. Clinical audit activities will examine the consistency and quality of the SMR process. The team have experience with health equity audit and will build on this to identify and tackle inequalities in access to and outcomes from medicines, including diagnosis, coding and clinical management.

Quality Priority: Promote a person-centred approach to safe and effective medicines use		
Service(s):	**Priority area**	**Quality domain**
Medicines Management	Integrated primary care and community pathway development	• Safe • Effective • Good experience • Affordable today • Sustainable tomorrow
Why is it a priority?	**How will quality be improved?**	**Quality objectives**
• Clinical outcomes and patient satisfaction are likely to be better when decisions about medicines are made jointly between the person taking the medicine and the prescriber • All clinicians within the Trust have responsibility for ensuring they are prescribing safely in line with best evidence based practice • The safe and appropriate use of medicines will ensure the best clinical outcomes for our population	• Clinical audit with primary care network specific action plans • Continuous monitoring of prescribing data to highlight areas of improvement • Use of prescribing support systems (for example EMIS protocols, Pincer, Optimise Rx) • Focused root cause analysis reviews of data related to hospital admissions related to medicines (HARMS) • Patient centred structured medication reviews for patients prescribed repeat medication with an emphasis on poly-pharmacy • Support and promote the reporting of medicines-related safety incidents to enable system wide learning • Improve medicines adherence	• Improve learning from medicines-related patient safety incidents to guide practice and minimise patient harm • Improve the safe and effective use of medicines to enable patients to get the best possible outcome from their medicines

	• Scope of practice competency review for all non-medical prescribers considering personal development needs • Promote antimicrobial stewardship • Promote adherence to evidence based prescribing guidelines and policy • Collaborative work within a multidisciplinary team providing expert advice on medicines related interventions • Develop a comprehensive work plan focused on our clinical and quality priorities	

Quality Priority: Development of an integrated Electronic Patient System (EMIS)		
Service(s):	**Priority area**	**Quality domain**
School Nursing	**Underpinning clinical systems and processes**	• **Safe** • **Effective** • **Sustainable tomorrow**
Why is it a priority?	**How will quality be improved?**	**Quality objectives**
• All staff have a responsibility to record contacts with patients/ clients contemporaneously • Provides evidence of continuity of care • Good practice	• Access to up to date patient records/ treatment improves contact for the client and practitioners will have knowledge of historical services • Staff will have excellent record keeping • Provide integrated care to the population	• Improved record keeping across all staff in Trust • Robust data protection policies

Quality Priority: Establish a community Learning Disability wellbeing service		
Service(s):	**Priority area**	**Quality domain**
Primary Care Development	**Protecting and supporting vulnerable people**	• **Safe** • **Effective** • **Sustainable tomorrow**
Why is it a priority?	**How will quality be improved?**	**Quality objectives**
• Develop a clinical operational model • Establish a multidisciplinary team that works across health and social care agencies • Reduce unwarranted variation in quality and outcomes • Ensure a consistent systematic approach • Address safeguarding needs of learning disabilities population effectively	• Staff will feel better equipped to support the people with learning disabilities • Reduced variation • Improved approach to address safeguarding needs • Improved patient experience	• Develop a quality assurance process around the learning disabilities health check • Improve health and wellbeing of people with learning disabilities

Quality Priority: To develop a specific homeless pathway and outreach service		
Service(s):	**Priority area**	**Quality domain**
Primary Care Development	**Protecting and supporting vulnerable people**	• **Safe** • **Effective** • **Good experience** • **Sustainable tomorrow**
Why is it a priority?	**How will quality be improved?**	**Quality objectives**
• No specific current service provision • Provision of services for homeless people is ad-hoc and will be very dependent on the practice they are registered with	• Improved access to medical care • Improved continuity of care	• Develop a pathway

Quality Priority: Further roll out and expansion of the First Contact Musculoskeletal (MSK) Practitioner		
Service(s):	**Priority area**	**Quality domain**
Primary Care Development	**Integrated primary care and community pathway development**	• **Safe** • **Effective** • **Good experience** • **Affordable today** • **Sustainable tomorrow**
Why is it a priority?	**How will quality be improved?**	**Quality objectives**
• Rolling expansion of the programme to ensure 100% coverage of the Dudley population	• An MSK assessment with a practitioner who is better equipped to make a diagnosis and onward referral for diagnostics where required • Improving access to, and capacity of, general practice	• Develop a safe and effective model in line with national standards set by Health Education England (HEE) • Reduce unwarranted variation in quality and outcomes • Suitable model for safe clinical supervision of Allied Health Professionals (AHPs) • Ensure our AHPs are suitably accredited to be first contact practitioners (FCPs) via HEE FCP and assistant practitioner roadmap to ensure patient safety and quality of care • Ensure appropriate use of the service – education and training during implementation with appropriate monitoring

Quality Priority: Establish a community based MSK/ Pain clinic		
Service(s):	**Priority area**	**Quality domain**
Primary Care Development	**Integrated primary care and community pathway development**	• **Safe** • **Effective** • **Good experience** • **Sustainable tomorrow**
Why is it a priority?	**How will quality be improved?**	**Quality objectives**
• Developing increased capacity and activity in to the community setting • Utilising the skills of GPs who have undertaken portfolio career development	• Improving access and capacity to services within a community setting • Improved patient experience	• Establish a multidisciplinary team to operate in a community setting • Improve the appropriateness of secondary care referrals including capacity • Improve patient experience by offering a more holistic approach • Ensure development is clearly embedded into the overarching MSK pathway

Service User and Staff Experience

Quality Priority: Develop a robust Learning and Development strategy		
Service(s):	**Priority area**	**Quality domain**
All	**Underpinning clinical systems and processes**	• **Safe** • **Effective** • **Good experience** • **Sustainable tomorrow**
Why is it a priority?	**How will quality be improved?**	**Quality objectives**
• A stable workforce enables targets to be met more fully • Trained and supported staff provide an enhanced service experience for clients • A clear strategy will ensure consideration of core clinical training requirements and encompasses clinical supervision	• All staff will receive training appropriate to their role • There will be a suitable model of clinical supervision	• Undertake a clinical training needs analysis • Undertake a safeguarding training needs analysis • To implement a model of safe clinical supervision of Allied Health Professionals • To implement a model for safeguarding supervision across all relevant services

Quality Priority: Deliver the Equality Diversity and Inclusion work programme		
Service(s):	**Priority area**	**Quality domain**
All	**Inclusivity and equitable access**	• **Safe** • **Effective** • **Good experience** • **Sustainable tomorrow**
Why is it a priority?	**How will quality be improved?**	**Quality objectives**
• Diversity and inclusion in the workforce leads to improved health and greater staff and patient experiences of the NHS. A diverse workforce enables the Trust to deliver a more inclusive service and improved patient care. The Trust wants to ensure that its workforce represents the community we serve.	• A diverse and inclusive workforce will ensure that no one feels left out at work. This work stream will enable the Trust to recognise and value differences through inclusion and enable DIHC to shape the future of healthcare and its workforce through becoming a more inclusive employer.	• Implement the DIHC equality, diversity and inclusion plan (2020-2022) • Launch and implement a process for values and competency based recruitment • Launch an anti-racism campaign endorsed and led by the Board

Quality Priority: To improve access to the IAPT service		
Service(s):	**Priority area**	**Quality domain**
Dudley Talking Therapies	**Inclusivity and equitable access**	• **Safe** • **Effective** • **Good experience**
Why is it a priority?	**How will quality be improved?**	**Quality objectives**
• To ensure equitable access to the whole population	• Referral material to be redesigned to ensure barriers are reduced • New ways of working embedded within the team • Regular service user groups	• To improve inclusion and access to all groups

Quality Priority: Development of service promotion		
Service(s):	**Priority area**	**Quality domain**
All	**Developing service user and staff engagement and feedback**	• **Safe** • **Effective** • **Sustainable tomorrow**
Why is it a priority?	**How will quality be improved?**	**Quality objectives**
• To increase awareness of our services throughout the wider community and alignment with other services	• To ensure people have access to support at the right time • To ensure people are signposted to the right services at the right time	• To have key links within each team that are able to be contacted to discuss promotions • To raise the profile of each service

Quality Priority: Development of a standardised Patient Reported Experience Measure (PREM)		
Service(s):	**Priority area**	**Quality domain**
Intermediate Care Team	**Developing service user and staff engagement and feedback**	• **Safe** • **Effective** • **Sustainable tomorrow**
Why is it a priority?	**How will quality be improved?**	**Quality objectives**
• To establish quality of service delivery in intermediate care rehabilitation facilities • To understand Individuals' experience following their stay in intermediate care rehabilitation facilities • To benchmark Dudley's rehabilitation facilities on a national platform	• Based upon the outcomes of the patient reported experience measures (PREM). Any areas requiring improvement will be addressed as a priority • The focus will be for all patients to have a positive experience during their stay in intermediate care facilities. Any areas for improvement will be addressed as a priority • Annual involvement in the National Audit of Intermediate Care (NAIC). Each year all CCGs are provided with a local bespoke summary of service provision in comparison to the national findings	• Develop a monthly auditing tool to capture any concerns or areas for improvement • The PREM form will offer providers confidence that individuals are involved in all areas of care decisions and goal setting within each rehabilitation facility • To ensure Dudley's rehab service provision stays within the top ten nationally. Any area of concern or underperforming areas will be addressed as a priority.

Quality Priority: Undertake a service expectation / feedback questionnaire for schools		
Service(s):	**Priority area**	**Quality domain**
School Nursing	**Developing service user and staff engagement and feedback**	• **Safe** • **Effective** • **Good experience** • **Affordable today** • **Sustainable tomorrow**
Why is it a priority?	**How will quality be improved?**	**Quality objectives**
• Forward planning for the service • Improve local public health • Improved service provision to schools and children, young people and their families	• Improved focus on delivering outcomes to improve population health	• Improved service to schools • High quality service provision • Cost effective

Statements of Assurance from the Board

All NHS providers must present certain information in their quality accounts, enabling the public to see a standardised and transparent view of what different healthcare organisations have reported. The mandatory quality statements in this section aim to offer assurance from the Board of Directors that the Trust is performing to essential standards, measuring our clinical processes and performance and focussed on improving quality.

Review of Services

During 2020-21, Dudley Integrated Health and Care NHS Trust provided and/or sub-contracted eight NHS services:

1. Adults Continuing Health Care (CHC)	CHC is the package of care arranged and funded by the NHS for individuals who are not in hospital but have complex ongoing healthcare needs. The DIHC NHS Continuing Healthcare Team provide assessment services on behalf of Dudley CCG who currently fund the packages of care.
2. Children's and Young Peoples' Continuing Care (CC)	CC is the package of care for children and young people who have complex ongoing healthcare needs that cannot be met by existing universal or specialist services alone.
3. High Oak Surgery	A comprehensively equipped GP practice run by DIHC.
4. Mental Health Services: Dudley Talking Therapy Services	Part of the national Improving Access to Psychological Therapies (IAPT) programme. Provides psychological support to over 16s in Dudley by offering a number of evidence-based therapies, advice and information.
5. Mental Health Services: Primary Care Mental Health Services	Supports individuals 16 and over who are experiencing a range of mental health problems. Primary care mental health nurses work from GP surgeries, offering assessment and brief intervention as part of Dudley's Integrated Care Teams (ICTs).
6. Pensnett Respiratory Assessment Centre	A primary care hub for COVID-19 symptomatic patients in Dudley needing to be seen by a health care professional.

7. Pharmaceutical Public Health	Team of clinical pharmacists providing support to every GP practice in Dudley with the aim of optimising the use of medicines by the people of Dudley.
8. Range of Primary Care Services	This includes services as described in the Primary Care Network Additional Roles Reimbursement Scheme, and includes Social Prescribing Link Workers, First Contact Physiotherapists, Health and Wellbeing Coaches, Clinical Pharmacists, Physician Associates, First Contact Podiatrists, Care Co-ordinators, Dietitians, Paramedics and Occupational Therapists.

Dudley Integrated Health and Care NHS Trust has reviewed all the data available to them on the quality of care in all of these services.

The income generated by the NHS services reviewed in 2020/21 represents 100% of the total income generated from the provision of NHS services by the Dudley Integrated Health and Care NHS Trust for 2020/21.

Clinical Audit

Clinical audit is a fundamental part of the quality improvement process. It plays an essential role to provide assurances to the public about the quality of our services. Findings from clinical audit are used to ensure that action is taken to protect patients from any risks associated with their care and treatment.

Clinical audit is managed at service level with the support of the medical directorate, with the Quality and Safety Committee approving the annual programme of clinical audits and having oversight of progress over the year

The pandemic has curtailed much of the audit programme that would typically have been undertaken. However, the Trust has ensured that it has remained focussed on required audits and those most pertinent to improving patient safety.

Pharmaceutical Public Health Team

The transfer of the Pharmaceutical Public Health team into DIHC brought with it a strong track record for delivering clinical audit, primarily through the team of practice based pharmacists, but also through collaboration with Birmingham University School of Pharmacy, providing valuable experience for their undergraduates.

The team's resources available for carrying out clinical audit has been particularly impacted by COVID-19 given their support to the setting up and delivery of the COVID-19 vaccination programme. However, they have continued to support key audits, both within the Trust and across wider primary care including:

- Audit of steroid card provision to ensure patients are issued with and carrying warning cards.
- Valproate audit – a continuous audit to ensure female patients are being supported by the Valproate Pregnancy Prevention Programme which aims to reduce the risk of birth defects associated with the treatment.
- Audit of communication between the local hospital and GPs relating to the provision and continued monitoring of the effects of COVID-19 treatments.
- Oversee the audits required by practices through the Medicines Optimisation Incentive Scheme (MOIS), predominantly antibiotic audits.

Clinical Research and Innovation

DIHC are committed to the principles of the NHS constitution supporting research and innovation, and are establishing an organisational culture to embrace this. This commitment and our intention to participate in clinical research demonstrates the DIHC commitment to improving the quality of care, improving patient safety and outcomes alongside helping clinical staff stay abreast of the latest treatment possibilities. We also recognise the value gained by supporting research and innovation in services, across pathways and systems and the benefits for a positive patient experience by ensuring the best evidence-based approach is utilised to improve health and care.

As a result we have formed a Research and Innovation group with the support of the National Institute of Health Research (NIHR) West Midlands Clinical Research Network (CRN). The purpose of this group is to ensure that our Trust is a research positive environment, raising the awareness of the importance of research and innovation but also enabling staff to explore ideas and share learning and good practice. The group's lead is the Medical Director ensuring the Trust follows the UK Policy Framework for Health and Social Care Research to become a research-ready organisation, and ultimately a research-active organisation. The Framework sets out the principles of good practice in the management and conduct of health and social care research and ensures the public will feel safe when they participate in research. The Trust recognises the importance of giving our patients wider access to clinical research and understands that evidence shows research-active NHS organisations have better patient care outcomes.

As a newly established Trust, functioning in the pandemic, we were keen to play an active role in the collection of COVID-19 related health care evidence. Therefore, while it was too early to undertake research independently, our Pensnett Respiratory Assessment Centre contributed to the evidence base in two areas of national research and innovation:

- **DIGNIO remote monitoring technology** had been used previously to monitor patients with Chronic Obstructive Pulmonary Disease (COPD). The application to monitoring patients with COVID-19 was an obvious utilisation of the technology. A simple phone App, with a Bluetooth pulse oximeter and thermometer were provided to patients attending the Pensnett Respiratory Assessment Centre and their data fed back to a dashboard. The ability to monitor patients in this way meant that fewer needed to be referred to secondary care. DIGNIO also fulfilled (and exceeded) the requirements of the national Oximetry @ Home initiative which started several months later and the evaluation was supported by the West Midlands Academic Health Science Network.

- **Oxford University RAPTOR study** was an assessment of the efficacy of various Lateral Flow Tests (point of care testing) against Polymerase Chain Reaction (PCR) tests and the Pensnett Respiratory Assessment Centre team recruited suitable patients to the study.

Goals agreed with Commissioners

Dudley Integrated Health and Care NHS Trust income in 2020-21 was not conditional on achieving quality improvement and innovation (CQUIN) goals through the Commissioning for Quality and Innovation payment framework because of the financial regime introduced as part of the COVID-19 response. Providers received block funding which was deemed to include CQUIN, however no CQUIN schemes were published during 2020/21.

Statements from the 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 2020 - 31 March 2021.

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 below.

	Safe	Effective	Caring	Responsive	Well-led	Overall
IAPT	Good	Good	Good	Good	Good	Good
PCMHS	Good	Good	Good	Good	Good	Good
High Oak Surgery	Good	Good	Good	Good	Good	Good

***Table 5**: summary of current CQC ratings*

During each of our phases of expansion, as services have transferred into the Trust, we have engaged with the CQC and continue to do so as we plan for next year's development.

Statement on relevance of Data Quality and our actions to improve Data Quality

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. Improving data quality will therefore help to improve patient care and improve value for money.

Dudley Integrated Health and Care NHS Trust will be taking the following actions to improve data quality:

- ensure the developing Trust Business Intelligence function provides support in improving data quality
- identify and develop data quality processes to ensure that data is accurate, timely and fit for purpose
- review existing information systems to ensure that they are fit for purpose
- act on the findings from the internal audit on IAPT data quality completed in 2020/21
- ensure clear agreements are in place for data quality with other organisations who we rely on for information provision
- maintain full compliance with the Data Information Standards
- produce Trust information submissions to reflect all statutory returns
- define an appropriate schedule of audits and checks on key data sets
- Implement dedicated Trust Data quality meetings
- Review and revise Standard Operating Procedures for data collection
- Identify training needs for staff regarding data quality and best practice

NHS Number and General Medical Practice Code Validity

Dudley Integrated Health and Care NHS Trust did not submit records during 2020-21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Data Security and Protection Assessment Report

The Data Security and Protection Toolkit (DSPT), based upon the National Data Guardian Standards, is an online, self-assessment tool that all organisations must use if they have access to NHS patient data and systems. Unlike the previous information governance

toolkit the DSPT does not provide a score or rating of the assessment so the Trust either met, or did not meet the DSPT standard. The Trust previously submitted the Data Security and Protection Toolkit in March 2020 and reported that it met compliance with mandatory assertions. In addition to the mandatory assertions, the Trust met 15 of the non-mandatory requirements.

Relevant data security training is mandatory for all staff within the Trust in accordance with national information governance standards and the Trust reported below the 95% mandated standards, this is following the reduction of training provision to meet clinical needs throughout the pandemic. The Trust ensures that all new starters complete their mandatory training within information governance and data security and all staff have completed the training within the past two years. However 100% of the Trust's Board have completed relevant information governance and data security training. To balance the training compliance the Trust have regular information governance communications sent to all staff and there are full actions plans in place to increase the training compliance across the Trust. Any incidents and/or risks associated with data and information security are reported and dealt with in accordance with the Trust risk management and incident reporting policies. _Due to the impact of COVID-19 the finalisation of the DSPT for 2020/21 is not set to be completed until June 2021. The Trust has monitored progress with the Data Security and Protection Toolkit closely and is on target to submit requirements met with action plans in place. Action plans are likely to be focussed around staff training compliance, as this is currently below the 95% standard. The table below provides an overview of what the Trust submitted in relation to the DSPT:

2020/21	Completed	Items Not Met	% Complete
Mandatory Requirements	**107**	**3***	**97.27**
Optional Requirements	**39**	**3**	**92.86**
Totals	**146**	**6**	**95.89**

**submitted as Not Met with Action Plan in place*

***Table 6**: Incidents reported to NRLS*

Clinical Coding Error Rate

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records.

Dudley Integrated Health and Care NHS Trust was not subject to the Payment by Results clinical coding audit during 2020-21 by the Audit Commission.

Reporting against Core Quality Indicators 2020/21

In this section, we report our performance against a defined set of core quality indicators – given the nature of our organisation and the services it currently provides, there is only one relevant indicator relating to patient safety incidents reported to the National Reporting and Learning System (NRLS).

Please note that another indicator relating to the CQC Community Mental Health survey is not applicable to Dudley Integrated Health and Care NHS Trust at this time.

Core Quality Indicators – Incident Reporting

The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports. All NHS trusts are required to report patient safety incidents to the NRLS every week. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care. This greater level of transparency provides an opportunity for the NHS at both local and national level to share experiences and learn from them.

This indicator covers the number of patient safety incidents reported within the Trust during 2020/21, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

2020/21	
Total incidents reported	**No. incidents resulting in severe harm or death**
39	1

***Table 7**: Incidents reported to NRLS*

The data above suggests a higher serious harm or death rate than one might expect from this Trust. This is due to a single Serious Incident (SI) reported in February 2021. The investigation carried out to date does not suggest that there was any direct link to the services we were providing.

Dudley Integrated Health and Care NHS Trust considers that this data is as described for the following reasons:

- The Trust has an open reporting culture which promotes learning and improvement
- Incident data is routinely reviewed and undergoes data quality checks to ensure that it is appropriate categorised

Dudley Integrated Health and Care NHS Trust intends to take the following actions to improve this percentage and the quality of its services by:

- Implementing RLDatix to provide a more robust system for reporting and managing incidents
- Implementing further systems for identifying learning and embedding lessons learnt from all incident reviews and investigations

Reporting against Local and other Quality Indicators

In this section of the report we present information on our performance against the following locally-defined and other indicators. It is important to note that the COVID-19 pandemic has impacted on the meaningful quality indicators available to measure during 2020/21. The Trust is committed to identifying an appropriate set of measures for 2021/22.

Metric	Target	Outturn	Comment on performance
Percentage of people completing a course of Improved Access to Psychological Therapies (IAPT) treatment moving to recovery	50%	45.6%	We have seen challenges due to a number of vacant hard-to-recruit posts in the IAPT team, exacerbated through the in-year introduction of our first contact practitioner model. We have however seen some improvements in our IAPT performance since 2019/20 (when the service was part of Dudley and Walsall Mental Health Partnership NHS Trust)
Percentage of people waiting i) 6 weeks or less from referral to entering a course of talking treatment under IAPT	75%	97.2%	The team have consistently achieved the waiting time targets throughout 2020/21.
Percentage of people waiting ii) 18 weeks or less from referral to entering a course of talking treatment under IAPT	95%	99.1%	The team have consistently achieved the waiting time targets throughout 2020/21.
Staff flu vaccination programme	75%	76%	The Trust have encouraged all staff to take up the offer of both the usual flu vaccination as well as the COVID-19 vaccination following its introduction in response to the pandemic. We recognise the importance of vaccinations in protecting both our staff and our service users, and are pleased that we have met the target for flu vaccinations.
Staff COVID-19 vaccination programme		89%	We will continue to encourage uptake of all relevant vaccinations in line with Government guidance and are looking at ways to maximise this through engagement with our staff.

Table 8: *Summary of local and other quality indicators*

Engagement in the development of the quality account

Prior to the publication of this Quality Account, we have shared it with the following:

- Our Trust Board
- Black Country and West Birmingham CCG
- Dudley Metropolitan Borough Council Health and Adult Social Care Scrutiny Committee
- Healthwatch Dudley

Statement from Black Country and West Birmingham CCG

We are pleased to comment on the Trust's 2020/21 Quality Account.

The CCG recognise that 20/21 has been an unprecedented year with the NHS as a team drawing on the expertise and support from all parts of the system. The impact of COVID-19 has had a far reaching impacting on both staff and patients in all sectors of the NHS.

Dudley Integrated Health Care (DIHC) formed in 2020 at the beginning of the pandemic with the ambition to integrate primary care with community services.

Setting up a new organisation during a pandemic has presented challenges, the focus of DIHC to ensure that both patients and staff were safe is to be commended.

The CCG notes the plan to focus on five pillars to include, safety, effectiveness and a good patient experience. The CCG accepts these as the foundations of the organisation with a clear focus on continuous development.

This Quality Account outlines how DIHC focused on bringing new services under one umbrella. The Trust report the successful amalgamation of a number of staff from differing backgrounds and organisations.

The CCG is pleased to note the commitment to a number of quality priorities to include improving access to IAPT services recognising that the demand for mental health services increased as a result of the COVID-19 pandemic and further, delivering the Equality Diversity and Inclusion Work programme. The Trust should be encouraged by establishment of the Pensnett Respiratory Assessment Centre in response to the COVID-19 pandemic.

The CCG recognises that the organisation has had to work hard to improve data as a result of navigating the challenges of different systems and processes. This variance has impacted on the quality of data which underpins the effective delivery of patient care. The CCG is encouraged by the Trust's commitment to improve the quality of data during 21/22 as this will support the focus on patient experience.

The Trust report the establishment of a robust incident management tool, RLDATIX. This electronic system supports the accurate and transparent recording of incidents, enabling teams to manage investigations, identify learning and embed lessons. The CCG is pleased that the Trust has adopted an open reporting culture which promotes reflective learning, improves development and protects patients from future harm.

We acknowledge the work of the Pharmaceutical Public Health Team who joined the organisation in October 2020, and played a pivotal role in the work to support the COVID-19 vaccination rollout. The work of this team has also supported wider partners to include the local authority and our care homes. It is positive to note that the pharmacy team has been able to successfully contribute to valuable audits during 2020 to enhance treatment offered within primary care settings.

The CCG is pleased that the Trust has committed to the principles of research and innovation despite the challenges faced throughout 2020/21, the plans put forward to build on this work as a priority are welcomed by the CCG.

Despite the pandemic a positive response rate for Friends and Family during 20/21 has been noted, overall the Trust has seen a positive response to experience of engaging with mental health services and the High Oak Surgery. The CCG also notes that the inception of the Pensnett Respiratory Assessment Centre was well received with a high percentage of patients satisfied with the service they received.

The CCG welcomes the introduction of service user and staff experience as part of the shift towards a culture of patient empowerment.

We note that a small number of complaints have been received with a comparative number of compliments. It is encouraging the Trust has noted the value of listening and responding to the issues highlighted and demonstrates the value of understanding the patient experience.

The CCG looks forward to the Trust achieving the ambitious plans to respond to the needs of the community whilst strengthening the processes which form the foundations of a strong and resilient organisation. The organisation has a journey ahead to ensure all systems and processes are embedded and data quality continues to improve. The commitment to share quality priorities to include a robust Safeguarding structure and the development of the Equality, diversity and inclusion work programme will be imperative. The CCG will continue to seek assurance at the monthly Clinical Quality Review Meetings to ensure that areas of concern receive oversight and scrutiny.

The CCG would like to thank the Trust for preparing this report which reviews aspects of service delivery during the first year of operation as the Dudley Integrated Health Care NHS Trust and outlines ambitious plans for the future.

Statement from Dudley Metropolitan Borough Council Health and Adult Social Care Scrutiny Committee

The Health and Adult Social Care Scrutiny Committee for Dudley Metropolitan Council were pleased to consider the draft 2020/21 Quality Reports and Accounts at their June 2021 meeting, this included the priorities set out for the respective services for the forthcoming year. The Committee supported ongoing close partnership working between the Council and the Trust, noting the Council had been involved in setting Key Performance Indicators. It was noted that effective partnership working would encourage the required culture change, develop a 'whole system' approach to the model of service and ensure that service users were seen by the most appropriate professional according to their needs. Reference was also made to engagement with recognised trade unions and the impact of national legislation on Integrated Care Systems. The need to capitalise on all opportunities to work in collaboration was important where shared objectives aligned to the Council Plan and Borough Vision, for example, in reducing health inequalities.

Statement from Healthwatch Dudley

Healthwatch Dudley acknowledges the very difficult period with SARS-Cov-2 infections and the spread of COVID-19 illness that health and care staff have had to respond to. The dedication and remarkable efforts of staff is much appreciated – including the work done to set up and operate the primary care Pensnett Respiratory Assessment Centre and support the rollout of vaccinations. At the same time, we thank the Trust for taking extra steps to bring in specialist staff to engage with communities and help to tackle inequalities in vaccine uptake.

Developments in the first year of operations

The Trust has been operational for just one year and yet, in the midst of an unprecedented pandemic period, there is much evidence of progress made in the development of its polices and the provision of healthcare services. We note that it is now providing Primary Care Mental Health and Talking Therapy services, Pharmaceutical Public Health services, and Intermediate Care and Continuing Care services. In addition, staff are being recruited to support the delivery of healthcare services within Primary Care Networks.

Other work, detailed in the report, that can make a big difference to the way people experience getting help with their healthcare and their safety includes the installation of the web-based patient safety reporting database, the development of robust safeguarding processes, support for individuals ordering prescriptions over the telephone, and the focus on improving the communications of medications changes when someone is discharged from hospital. We look forward, in future reports, to getting more information and insights on the development of the Trust's integrated care model, the healthcare services it provides, and how they are helping to improve the quality of healthcare for people living in the Dudley borough.

Accessibility and public engagement

We are very much interested in the Trust's strong commitment to being accessible and responsive – listening to local people, seeking out lesser heard voices and empowering individuals to be joint decision makers in their care. Again, we look forward to getting more evidence and information, in future reports, on how this commitment is translating into action on the ground and how people are able to influence policy making and the design and delivery of healthcare services.

It is noted, though, that there have been high levels of satisfaction reported with the Pensnett Respiratory Assessment Centre and, in the main, a positive response from individuals on the Mental Health Services Friends and Family Test. And there is public engagement happening with the Healthcare Forum and Patient Opportunity Panel (and representatives from Patient Participation Groups) meetings.

Looking Forward to 2021/22

We fully support the Trust's ambition to be a learning organisation based at the heart of the local community. In turn, we welcome the proposals to further develop its public engagement processes, Patient Safety and Safeguarding strategies, and the use of Structured Medication Reviews – to support individuals with monitoring medications to improve safety and effectiveness. And the decisions to set up a Community Learning Disability Wellbeing Service and Homelessness Pathway and Outreach service.

Statement of Director Responsibilities in respect of the Quality Account 2020/21

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011 and the National Health Service (Quality Accounts) Amendment Regulations 2012)).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review;
- the Quality Account has been prepared in accordance with Department of Health guidance

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Paul Assinder
Chief Executive Officer
29th June 2021

Harry Turner
Chair
29th June 2021

Glossary

Acronym	Term	Meaning / explanation
AHP	Allied Health Professionals	The 14 Allied Professional Services consisting of: Art Therapists, Drama therapists, Chiropodists/podiatrists, Dietitians, Occupational therapists, Operating Department Practitioners, Orthoptists, Osteopaths, Paramedics, Physiotherapists, Prosthetists and Orthotists, Radiographers & Speech and language therapists
AIS	Accessible Information Standards	The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.
APMS	Alternative Provider Medical Service	Alternative Provider Medical Services is a contracting route allow contracts with non-NHS bodies, such as voluntary or commercial sector providers, supply enhanced and additional primary medical services. APMS contracts can be with any individual or organisation to meet local needs, as long as core NHS values are fully protected and secured.
BCH	Black Country Healthcare NHS Foundation Trust	New Trust formed following the merger in April 2020 of Black Country Partnership NHS Foundation Trust and Dudley & Walsall Mental Health Partnership NHS Trust. NHS provider of acute mental healthcare services in Black Country. Hospital sites throughout the Black Country.
BAME	Black, Asian, and Minority Ethnic	To refer to members of non-white communities in the UK.
CCG	Clinical Commissioning Group	CCGs are clinically led groups that include all of the GP groups in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. They are overseen by NHS England.
CC	Children's and Young Peoples' Continuing Care	CC is the package of care for children and young people who have complex ongoing healthcare needs that cannot be met by existing universal or specialist services alone.
CDiF	Clostridium difficile	A type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics
CDoLs	Community Deprivation of Liberty Safeguards	The Deprivation of Liberty Safeguards is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.
CHC	Continuing Healthcare	NHS continuing healthcare is a free package of care for people who have significant ongoing healthcare needs

COPD	Chronic Obstructive Pulmonary Disease	Chronic obstructive pulmonary disease is the name for a group of lung conditions that cause breathing difficulties. It includes: emphysema – damage to the air sacs in the lungs. chronic bronchitis – long-term inflammation of the airways.
COVID-19	COVID-19	COVID-19 is caused by a new form of coronavirus known as SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2). It was first reported in December 2019.
CQC	Care Quality Commission	Quality regulator for health and social care providers. In 2010, introduced a system of 'registering' providers as a demonstration of quality
CQR	Clinical Quality Review	The Trust meets regularly with its Commissioners to discuss the quality and activity performance. Through these meetings, the Trust's key commissioners can hold the Trust to account
CQUIN	Commissioning for Quality and Innovation	CQUIN is a national initiative which aims to embed demonstrable quality improvements within the commissioning cycle for NHS healthcare. The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals
CRN	Clinical Research Network	The Clinical Research Network enables high-quality health and care research in England by meeting the costs of additional staff, facilities, equipment and support services so that research is not subsidised with funding that has been provided for health and care treatments and service.
DGFT	Dudley Group of Hospitals	NHS provider of acute healthcare services in Dudley. Main hospital site is Russells Hall. They are a Foundation Trust
DIHC	Dudley Integrated Health and Care NHS Trust	Our Trust, integrating primary care across Dudley with community physical and mental health services
DIPC	Director of Infection Prevention and Control	The Director of Infection Prevention and Control is a role required by all registered NHS care providers under current legislation who has the executive authority and responsibility for ensuring strategies are implemented to prevent avoidable healthcare associated infections at all levels in the organisation
DoLS	Deprivation of Liberty Safeguards [see PLS]	Linked to Mental Capacity Act, DOLS is a governance infrastructure usually used for people in hospitals or care homes who may need to be deprived of their liberty in some way to protect them from harm
DSPPB	Dudley Safeguarding People Partnership Board	Public bodies in Dudley working together in partnership to ensure safeguarding arrangements for children and adults are in place and working in Dudley
DSPT	Data Security and Protection Toolkit	An online, self-assessment tool that all organisations must use if they have access to NHS patient data and systems.

DWMH	Dudley and Walsall Mental Health Partnership NHS Trust	Former mental health Trust which merged with Black Country Partnership to form Black Country Healthcare NHS Foundation Trust.
E.coli	E.coli	E.coli is a type of bacteria that normally live in the intestines of people and animals. Some types of E.coli can cause intestinal infection
EDS	Equality Delivery System	It is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010.
EMIS	Egton Medical Information Systems	The principal clinical system used by all GPs in Dudley which stores the core electronic patient record
EqIAs	Equality Impact Assessments	Equality Impact Assessments are tools which ensures equality analysis is carried out as required by law
FCP	First Contact Practitioners	The health professional that is able to see patients without the need to be referred by a GP, to make a more rapid assessment of the patient and refer onwards if necessary
FFT	Friends & Family Test	A survey to help service providers and commissioners understand whether service users are happy with the service provided, or where improvements are needed
FT	Foundation Trust	Type of NHS provider organisation which has more autonomy and different governance arrangements.
HARMS	Hospital Admissions Related to Medicines	
HCAI	Healthcare-associated Infections	Healthcare-associated infections can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting.
HR	Human Resources	The personnel of a business or organization, regarded as a significant asset in terms of skills and abilities
IAPT	Improving Access to Psychological Therapies	One of the Trust's services, transferred over on 1st April 2020. An NHS programme rolling out services across England offering interventions for treating people with depression and anxiety disorders
ICP	Integrated Care Provider / Partnership	Integrated Care Providers bring together primary, secondary, community and other health and social care services under a single contract. The intention is to focus on population health by designing and delivering all health and care services for the local community within an agreed budget

ICS	Integrated Care System	An ICS brings NHS providers, Clinical Commissioning Group (CCGs), local authorities and voluntary sector partners together to collaboratively plan and organise how health and care services are delivered in their area.
ICT	Integrated Care Team	Integrated care teams give people the support they need, joined up across local councils, the NHS, and other partners
IPC	Infection Prevention and Control	A scientific approach and practical solution designed to prevent harm caused by infection to service users and health workers
LD	Learning Disabilities	A learning disability affects the way a person learns new things throughout their lifetime. It affects the way a person understands information and how they communicate. A learning disability can be mild, moderate, or severe. Some individuals with a learning disability are able to live independently, while others need help with everyday tasks
LPS	Liberty Protection Safeguards	Liberty Protection Safeguards provide protection for people aged 16 and above who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements
MOIS	Medicines Optimisation Incentive Scheme	The Medicines Optimisation Incentive Scheme is designed to increase value for money by improving the quality and cost effectiveness of primary care prescribing.
MRSA	Methicillin-resistant Staphylococcus aureus	MRSA is a common skin bacterium that is resistant to a range of antibiotics, including methicillin. 'Methicillin-resistant' means the bacteria are unaffected by the methicillin. About 1/3 of us carry the SA bacteria on the surface of our skin or in our nose without developing infection, this is known as being colonised by the bacteria. MRSA infection occurs when the bacteria enter the body through a break in the skin and multiply, causing various symptoms (often swelling and redness at the site of infection)
MSSA	Methicillin-sensitive Staphylococcus aureus	Methicillin-sensitive Staphylococcus aureus is a skin infection that is not resistant to certain antibiotics
MSK	Musculoskeletal	Relating to or denoting the musculature and skeleton together
NAIC	National Audit of Intermediate Care	The National Audit of Intermediate Care takes a whole system view of the effectiveness of intermediate care, to develop quality standards and patient outcome measures and to assess local performance against the agreed, national standards
NHS	National Health Service	The umbrella term for the publicly-funded healthcare systems of the United Kingdom

NHSE/I	NHS England and NHS Improvement	NHS England and NHS Improvement were previously separate entities, but now form a new integrated leadership structure, and are a non-departmental public body of the Department of Health and Social Care Jointly they oversee the budget, planning, delivery and day-to-day operation of both the commissioning and provider side of the NHS in England, as well as independent providers that provide NHS-funded care
NRLS	National Reporting and Learning System	The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports
PCN	Primary Care Network	Primary care networks (PCN) are groups of practices working together to focus local patient care
PCR	Polymerase Chain Reaction	Polymerase Chain Reaction tests for COVID-19
PCMHS	Primary Care Mental Health Services	Primary Care Mental Health Services supports individuals aged 16 or over (school leavers) who are registered with a Dudley CCG GP and experiencing a range of mental health problems
POD	Pharmacy Ordering Direct	Pharmacy Ordering Direct allows patients from certain surgeries to order their own prescriptions through a centralised 'phone system
PREM	Patient Reported Experience Measure	Patient-reported experience measures are questionnaires measuring the patients' perceptions of their experience whilst receiving care.
PSED	Public Sector Equality Duty	The public sector equality duty is a duty on public authorities to consider or think about how their policies or decisions affect people who are protected under the Equality Act
RLDatix	Electronic system of risk reporting (incidents/complaints etc)	An electronic system used to report clinical incidents, complaints and risks
SI	Serious Incident	Any unplanned occurrence which has actual or potential negative impact
WDES	Workforce Disability Equality Standard	Is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of Disabled and non-disabled staff. NHS trusts use the metrics data to develop and publish an action plan
WRES	Workforce Race Equality Standard	It provides an overview of the data on all nine WRES indicators and where possible, comparison against data from previous years Understanding the data is one of the steps in helping organisations to develop evidence-based action plans, to improve on the workforce race equality agenda

How to provide feedback

If you would like to give us feedback on this report or to obtain the report in a different format, for instance in larger print or a different language please contact dihc.contactus@nhs.net.

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