

CITY OF  
WOLVERHAMPTON  
COUNCIL

# Health Scrutiny Panel

7 November 2019

<b>Time</b>	1.30 pm	<b>Public Meeting?</b>	YES	<b>Type of meeting</b>	Scrutiny
<b>Venue</b>	Committee Room 3 - Civic Centre, St Peter's Square, Wolverhampton WV1 1SH				

## Membership

**Chair** Cllr Phil Page (Lab)  
**Vice-chair** Cllr Paul Singh (Con)

Cllr Obaida Ahmed  
Cllr Bhupinder Gakhal  
Cllr Milkinderpal Jaspal  
Cllr Lynne Moran  
Cllr Susan Roberts MBE  
Cllr Wendy Thompson  
Tracey Cresswell (Healthwatch)  
Sheila Gill (Healthwatch)  
Dana Tooby (Healthwatch)

Quorum for this meeting is three voting members.

## Information for the Public

If you have any queries about this meeting, please contact the Democratic Services team:

**Contact** Martin Stevens  
**Tel/Email** Tel: 01902 550947 or [martin.stevens@wolverhampton.gov.uk](mailto:martin.stevens@wolverhampton.gov.uk)  
**Address** Democratic Services, Civic Centre, 1<sup>st</sup> floor, St Peter's Square,  
Wolverhampton WV1 1RL

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# Agenda

## Part 1 – items open to the press and public

*Item No.*      *Title*

### MEETING BUSINESS ITEMS

- 1      **Apologies**
- 2      **Declarations of Interest**
- 3      **Minutes of previous meeting** (Pages 3 - 6)  
[To approve the minutes of the previous meeting as a correct record.]
- 4      **Matters Arising**  
[To consider any matters arising from the minutes.]

### DISCUSSION ITEMS

- 5      **Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024 - Health Scrutiny Panel** (Pages 7 - 32)  
[To consider a report on the Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024].
- 6      **Wolverhampton CCG Annual Report 2018-19** (Pages 33 - 172)  
[To consider the Wolverhampton CCG Annual Report 2018-19].
- 7      **GP Appointment Waiting Times** (Pages 173 - 178)  
[To consider a report from Wolverhampton CCG on GP Appointment Waiting Times].
- 8      **GP Communication Report - Healthwatch** (Pages 179 - 194)  
[To consider the GP Communication report produced by Healthwatch].
- 9      **Public Health Annual Report 2018-19** (Pages 195 - 274)  
[To consider the Public Health Annual Report 2018-19].
- 10     **Healthwatch Wolverhampton Annual Report 2018-19** (Pages 275 - 318)  
[To consider the Healthwatch Annual Report 2018-19].
- 11     **Development of the Medical Examiner Role and on site Registrar** (Pages 319 - 324)  
[To consider a report on the Development of the Medical Examiner Role and on site Registrar].
- 12     **Health Scrutiny Work Programme** (Pages 325 - 328)  
[To consider the Health Scrutiny Work Programme].

# Health Scrutiny Panel

Minutes - 12 September 2019

Agenda Item No: 3

## Attendance

### Members of the Health Scrutiny Panel

Cllr Obaida Ahmed  
Tracy Cresswell  
Cllr Bhupinder Gakhal  
Cllr Milkinderpal Jaspal  
Cllr Lynne Moran  
Cllr Phil Page (Chair)  
Cllr Paul Singh (Vice-Chair)  
Cllr Wendy Thompson  
Dana Tooby

### In Attendance

Cllr Sohail Khan  
Cllr Jane Stevenson  
Cllr Jonathan Crofts

### Witnesses

Eleanor Smith MP  
Stuart Anderson (Prospective Conservative Parliamentary Candidate)  
Helen Hibbs (Chief Officer - CCG)  
Steven Marshall (Director of Strategy and Transformation CCG)  
Anja Ellersiek (Campaign Group to save Tettenhall Wood Road Surgery)  
Representative from NHS England  
Sue Sephton (Practice Manager Tettenhall Medical Practice)  
X 2 GP's from Tettenhall Medical Practice

### Employees

Martin Stevens (Scrutiny Officer) (Minutes)  
John Denley (Director for Public Health)  
Julia Cleary (Scrutiny and Systems Manager)  
Heather Harper (Apprentice Systems Officer)  
Earl Piggott-Smith (Scrutiny Officer)  
Amy Pote (Apprentice Systems Officer)

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## Part 1 – items open to the press and public

*Item No.*      *Title*

1      **Apologies**

Apologies for absence were received from Cllr Susan Roberts MBE, Cllr Paul Brookfield and Sheila Gill.

The Health Scrutiny Panel were made aware that Sheila Gill had recently suffered a family bereavement and sent their condolences to her.

2 **Declarations of Interest**

Cllr Bhupinder Gakhal declared a non-pecuniary interest on the item on the consultation on the Tettenhall Wood Road GP Surgery as he worked in the Constituency Office for Eleanor Smith MP.

Cllr Milkinderpal Jaspal declared a non-pecuniary interest on the item on the consultation on the Tettenhall Wood Road GP Surgery.

3 **Minutes of previous meeting**

**Resolved:** That the minutes of the Health Scrutiny Panel meeting held on 6 June 2019 be approved as a correct record.

4 **Matters Arising**

The Director for Public Health remarked that the latest suicide figures for the Wolverhampton area had recently been released. He was pleased to report that suicides had decreased in Wolverhampton which was against the national trend. In Wolverhampton suicides had dropped from 23 to 15.

Cllr Milkinderpal Jaspal requested a meeting with the Director for Strategy and Transformation of the CCG regarding clarification of the Accident and Emergency figures he had recently submitted to the Health Scrutiny Panel by email. The Director for Strategy and Transformation agreed to hold a meeting with the Councillor.

5 **Tettenhall Wood GP Surgery Consultation**

The Chairman gave an opening statement explaining the purpose and role of the Health Scrutiny Committee. He also explained that there was a comments box at the venue, which people could use to submit comments about the consultation on the Tettenhall Wood Road GP Surgery. There were also hard copies available of the official consultation for those that hadn't already completed it. He and the Vice-Chair had visited the Tettenhall Wood Road Surgery on 3 September to see the facilities, car parking arrangements and to meet some of the medical staff. He had made available at the venue a map showing all the public transport routes in Wolverhampton and Members had before them a map showing the location of the two surgeries run by the Tettenhall medical practice.

The Panel received statements from the Accountable Officer at the CCG (Helen Hibbs), a representative from the campaign to save the Tettenhall Wood Road Surgery (Anja Ellersiek), Eleanor Smith MP, Mr Stuart Anderson (Conservative prospective candidate for Wolverhampton South West Parliamentary Seat), Local Councillors – Cllr Sohail Khan, Cllr Jane Stevenson, Cllr Jonathan Crofts, Panel Member and Local Member – Cllr Wendy Thompson, a representative from the medical practice and a representative from NHS England.

The Campaign to save the Tettenhall Wood Road Surgery had also submitted a written statement to the Panel Members, a copy of which is attached to the signed minutes. The GP Practice Manager after a request from the Chair of the Panel had

submitted a spreadsheet showing the age groupings of patients that used the two surgeries run by the Tettenhall Medical Practice.

After a detailed discussion the Panel,

**Resolved Unanimously:** -

- A) That Wolverhampton CCG use all their best endeavours, working in collaboration with the Tettenhall Medical Practice, to keep the Tettenhall Wood Road Surgery open.
- B) That the Health Scrutiny Panel be formally notified by the CCG of the outcome of the planned Primary Care Commissioning Committee scheduled for November.
- C) That the Chair of the Health Scrutiny Panel write to the relevant Council Officers to see what steps can be taken to help improve the current car parking arrangements at the Tettenhall Wood Road Surgery.

6

**The Royal Wolverhampton NHS Trust - Quality Accounts**

Representatives from the Royal Wolverhampton NHS Trust gave a presentation on the final quality accounts. A copy of the presentation slides had been circulated with the agenda and are attached to the signed minutes.

7

**National Audit End of Life Care**

Representatives from the Royal Wolverhampton NHS Trust gave a presentation on the National Audit of End of Life Care, a copy of the report circulated with the agenda is attached to the signed minutes.

Cllr Khan asked when the Panel would receive a report reviewing the impact of the new Medical Examiner role. The Scrutiny Officer confirmed that a report was scheduled to be received by the Panel at their meeting in January 2020.

8

**Verbal Update on Brexit Preparations**

Health partners gave a verbal update on their preparations for Brexit.

The Director for Public Health commented that they were treating Brexit as any emergency planning preparedness or continuity type exercise. There were five sub groups relating to different parts of the Council, that were looking at their preparedness. One of those was related to Health and Social Care.

The CCG Chief Accountable Officer gave an update on the preparations the CCG were undertaking. They were making sure that good plans were in place for Brexit and were contributing to the meetings being held on the subject.

The Deputy Chief Nurse of the Royal Wolverhampton NHS Trust gave an update on the preparations the Trust were making. Their risk assessment was being updated every two weeks. They were used to managing shortages of drugs with pharmacies.

9

**Work Programme**

**Resolved:** That the Health Scrutiny Work Programme be agreed.

[NOT PROTECTIVELY MARKED]

Agenda Item No: 5



## Health Scrutiny Panel

7 November 2019

<b>Report title</b>	Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024		
<b>Decision designation</b>	AMBER		
<b>Cabinet member with lead responsibility</b>	Councillor Jasbir Jaspal Public Health & Wellbeing		
<b>Corporate Plan priority</b>	Confident Capable Council		
<b>Key decision</b>	Yes		
<b>In forward plan</b>	Yes		
<b>Wards affected</b>	All		
<b>Accountable Director</b>	Claire Nye, Director of Finance		
<b>Originating service</b>	Strategic Finance		
<b>Accountable employee</b>	Alison Shannon	Chief Accountant	
	Tel	01902 554561	
	Email	Alison.shannon@wolverhampton.gov.uk	

### Report to be/has been considered by

### Recommendations for decision:

The Panel is recommended to:

1. Provide feedback to Scrutiny Board for consolidation and onward response to Cabinet on the budget relevant to the remit of this Panel and how it is aligned to the priorities of the Council.
2. Provide feedback to Scrutiny Board for consolidation and onward response to Cabinet on Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024 including budget proposals that are relevant to the remit of this Panel.
3. Approve that the Scrutiny Panel response be finalised by the Chair and Vice Chair of the Scrutiny Panel and forwarded to Scrutiny Board for consideration.

## **1.0 Purpose**

- 1.1 The purpose of this report is to seek the Panel's feedback on the budget relevant to the remit of this Panel and how it is aligned to the priorities of the Council. In addition to this, the Panel's feedback is also sought on the Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024 that was presented to Cabinet on 16 October 2019 including budget proposals relevant to the remit of this Panel.

## **2.0 Draft Budget and Medium Term Financial Strategy Background**

- 2.1 Since 2010-2011 despite the successive cuts in Council resources, which have led to significant financial challenges, the Council has set a balanced budget in order to deliver vital public services and city amenities. Over the last eight years the Council has identified budget reductions in excess of £220 million. The extent of the financial challenge over the medium term continues to represent the most significant challenge that the Council has ever faced, with reducing resources, growing demand for services and significant cost pressures.
- 2.2 The Budget and Medium Term Financial Strategy (MTFS) 2019-2020 to 2023-2024 was presented to Full Council for approval on 6 March 2019. The Council was able to set a balanced budget for 2019-2020 without the use of General Fund reserves. However, it was projected that the Council would be faced with finding further estimated budget reductions totalling £27.3 million in 2020-2021 rising to £40-£50 million over the medium term to 2023-2024.
- 2.3 Since then, work has been ongoing across the Council to identify opportunities in line with the Five Year Financial Strategy to support the budget strategy for 2020-2021 and future years, whilst also analysing emerging pressures and potential resources available to the Council, following the Spending Round 2019 announcement on 4 September 2019.

## **3.0 Our Council Plan 2019-2024**

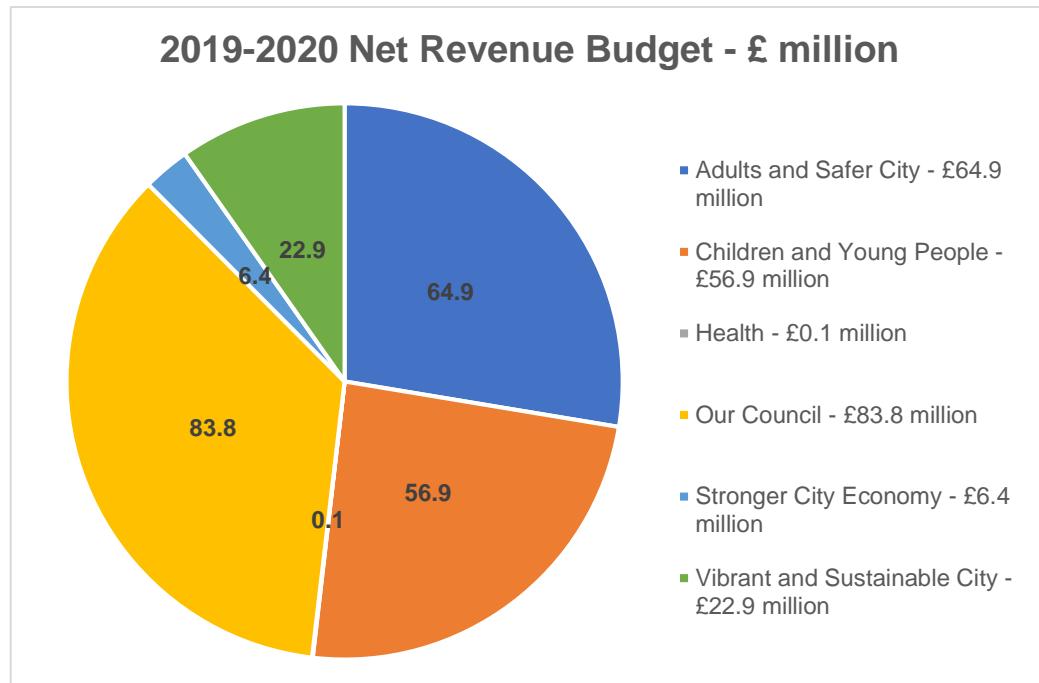
- 3.1 The Council's strategic approach to address the budget deficit continues to be to align resources to Our Council Plan 2019-2024 which was approved by Full Council on 3 April 2019.
- 3.2 Our Council Plan, developed with the people of the City of Wolverhampton at its heart, sets out how we will deliver our contribution to Vision 2030 and how we will work with our partners and communities to be a city of opportunity. The plan includes six strategic priorities which come together to deliver the overall Council Plan outcome of 'Wulfrunians will live longer, healthier and more fulfilling lives.' Over the medium term, resources will continue to be aligned to enable the realisation of the Council's strategic priorities of achieving:
- Children and Young People get the best possible start in life
  - Well skilled people working in an inclusive economy
  - More good jobs and investment in our city
  - Better homes for all

- Strong, resilient and healthy communities
  - A vibrant, green city we can all be proud of.
- 3.3 All of the strategic outcomes will be supported by the ‘Our Council’ Programme, which will help us drive organisational improvement and development.
- 3.4 The Financial Strategy, approved by Council in March 2019, consists of five core principles underpinned by eight core workstreams. Using the Core Workstreams as the framework for the Financial Strategy detailed delivery plans are being developed all with a lead director. The core principles are:
- **Core Principles:**
    - **Focusing on Core Business.** Focus will be given to those activities that deliver the outcomes local people need and which align to our Council Plan and Financial Strategy.
    - **Promoting Independence and Wellbeing.** We will enable local people to live independently by unlocking capacity within communities to provide an effective and supportive environment.
    - **Delivering Inclusive Economic Growth.** We will continue to drive investment in the City to create future economic and employment opportunities.
    - **Balancing Risk.** We will ensure we base decisions on evidence, data and customer insight.
    - **Commercialising our Approach.** We will boost social value in our City by maximising local procurement spend with people and businesses.

#### 4.0 Budget - Health Scrutiny Panel remit

- 4.1 As detailed above, when addressing the budget challenge, the Council continues to focus on aligning its resources to strategic outcomes.
- 4.2 The Council holds a net revenue expenditure budget totalling £234.9 million for the 2019-2020 financial year. Of this, services relevant to the remit of the Health Scrutiny Panel have net revenue expenditure budgets in the region of £100,000, as can be seen in Chart 1 below.

**Chart 1 – Net Revenue Budget 2019-2020**



- 4.3 Contained within the net revenue budget for this area is £20.2 million Public Health grant funded expenditure.
- 4.4 Part of the conditions of the Public Health grant are to deliver mandated public health services. These include:
  - Healthy Child Programme (Health visiting and school nursing services)
  - Sexual Health open access
  - NHS health checks
- 4.5 Additionally, the grant is used to commission substance misuse services, and a range of health protection services. The conditions of the Public Health Grant also include the offer of expertise, support and advice to local NHS partners.

## **5.0 Key Strategies and Transformation**

- 5.1 The revenue budgets allocated enable an approach to improving the health and wellbeing of the population that is outlined in the Public Health Vision 2030. The aspirations in the vision are closely aligned to the Health and Wellbeing Strategy 2018-2023 and the Council Plan 2019-2024, which has a commitment to Wulfrunians living healthier, longer, more fulfilling lives as its central objective.
- 5.2 Over the past year, the work to improve health and wellbeing has been underpinned by developing strong arrangements with anchor institutions in the city such as Royal Wolverhampton Hospitals NHS Trust. The intention behind such partnerships is to bring much needed stability into the 'system' and enable more collaborative working, rather than the traditional 'commissioner-provider split'.
- 5.3 There have been some notable successes in the first year. These include:
  - Reducing the number of rough sleepers which contrasts with national trends
  - Increasing the number of health checks offered to our eligible populations – the City has moved from one of the lowest performing areas to top quartile within the year
  - More people recovering from substance misuse and finding employment
  - Significant improvement in flu vaccination uptake
  - Movement from lowest performing to second highest in the region for chlamydia detection
  - Healthy Child programme performance is at its highest since Public Health transferred to Council in 2013.
- 5.4 These successes serve as an invaluable springboard from which we seek to address some longstanding health challenges witnessed in the city such as poor uptake of cancer screening services. In the year ahead, as part of the efforts to achieve improvements, Public Health will build on the ward-based work that has commenced in recent months. This will provide opportunity to address key health inequalities in specific neighbourhoods.

## **6.0 Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024**

- 6.1 Since March 2019, Cabinet have been provided with two further Budget and Medium Term Financial Strategy (MTFS) updates in July and October 2019 to identify opportunities in line with the Five Year Financial Strategy to support the budget strategy for 2020-2021 and future years.
- 6.2 In October 2019, Cabinet were presented with the Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024 report in which it was forecast that, after taking into account projected changes to corporate resources and emerging pressures, the projected remaining budget deficit for 2020-2021 would be in the region of £3.9 million, rising to £20 million over the medium term period to 2023-2024.
- 6.3 The MTFS includes provision for a real-terms increase to the Public Health grant budget in 2020-2021, announced by Government in the Spending Round 2019, to ensure local

authorities can continue to provide prevention and public health interventions. The additional funds will support the provision of public health and wellbeing across the City.

- 6.4 Appendix 1 provides a copy of the 'Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024' report for your consideration. There are no specific budget proposals relevant to the remit of this Panel, however, all proposals can be found at [www.wolverhampton.gov.uk/financialstrategy](http://www.wolverhampton.gov.uk/financialstrategy). Feedback from this and the other Scrutiny Panel meetings will be reported to Scrutiny Board on 10 December 2019, which will consolidate that feedback in a formal response to Cabinet on 22 January 2020. The feedback provided to Scrutiny Board will include questions asked by Panel members, alongside the responses received. Cabinet will take into account the feedback from Scrutiny Board when considering the final budget setting report in February 2020, for approval by Full Council in March 2020.

## **7.0 Panel Recommendations**

- 7.1 The Panel are recommended to provide feedback to Scrutiny Board for consolidation and onward response to Cabinet on:
- the budget relevant to the remit of this Panel and how it is aligned to the priorities of the Council;
  - the Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024 and budget proposals relevant to the remit of this Panel;
  - any other comments.

- 7.2 The Panel are also recommended to approve that the Scrutiny Panel response be finalised by the Chair and the Vice-Chair of the Scrutiny Panel and forwarded to Scrutiny Board for consideration.

## **8.0 Financial implications**

- 8.1 The financial implications are discussed in the body of the report, and in the report to Cabinet.  
[MH/30102019/O]

## **9.0 Legal implications**

- 9.1 The legal implications will be included in the report to Cabinet, the Scrutiny Board having only an advisory role.  
[LW/30102019/F]

## **10.0 Equalities implications**

- 10.1 The equalities implications are discussed in the report to Cabinet.

## **11.0 Environmental and climate change implications**

- 11.1 The environmental and climate change implications are discussed in the report to Cabinet.

## **12.0 Human resources implications**

- 12.1 The human resources implications are discussed in the report to Cabinet.

## **13.0 Corporate landlord implications**

- 13.1 The Corporate Landlord implications are discussed in the report to Cabinet.

## **14.0 Health and wellbeing implications**

- 14.1 The Corporate Landlord implications are discussed in the report to Cabinet.

## **15.0 Schedule of background papers**

Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024, report to Cabinet, 16 October 2019.

Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024, report to Cabinet, 31 July 2019.

2019-2020 Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024, report to Full Council, 6 March 2019

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<b>CITY OF WOLVERHAMPTON COUNCIL</b>	<b>Cabinet</b> <b>16 October 2019</b>
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<b>Report title</b>	Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024		
<b>Decision designation</b>	AMBER		
<b>Cabinet member with lead responsibility</b>	Councillor Louise Miles Resources		
<b>Key decision</b>	Yes		
<b>In forward plan</b>	Yes		
<b>Wards affected</b>	All Wards		
<b>Accountable director</b>	Tim Johnson, Chief Executive		
<b>Originating service</b>	Strategic Finance		
<b>Accountable employee</b>	Claire Nye Tel Email	Director of Finance 01902 550478 claire.nye@wolverhampton.gov.uk	
<b>Report to be/has been considered by</b>	Strategic Executive Board Health Scrutiny Panel Vibrant and Sustainable City Scrutiny Panel Adults and Safer City Scrutiny Panel Our Council Scrutiny Panel Stronger City Economy Scrutiny Panel Children and Young People Scrutiny Panel Scrutiny Board	2 October 2019 7 November 2019 7 November 2019 12 November 2019 20 November 2019 25 November 2019 27 November 2019 10 December 2019	

**Recommendations for decision:**

The Cabinet is recommended to approve:

1. The updated draft budget strategy linked to the Five Year Financial Strategy, including the budget reduction and income generation proposals and one-off funding opportunities.
2. That further options are explored between October 2019 and January 2020 to address the updated projected budget deficit of £3.9 million for 2020-2021 and the medium term, based on the Council's Five Year Financial Strategy.

3. That authority be delegated to the Cabinet Member for Resources, in consultation with the Director of Finance, to approve the final budget consultation arrangements.

**Recommendations for noting:**

The Cabinet is recommended to note:

1. That, a number of assumptions have been made with regards to the level of resources that will be available to the Council as detailed in section 5 of this report. It is important to note that there continues to be a considerable amount of uncertainty with regards to future income streams for local authorities over the forthcoming multi-year Spending Review period. At the point that further information is known it will be incorporated into future reports to Councillors. Any reduction in the Government's allocation of funding to the Council would have a significant detrimental impact and further increase the budget deficit forecast over the medium term.
2. That, due to external factors, budget assumptions remain subject to significant change, which could, therefore, result in alterations to the financial position facing the Council.
3. That the projected remaining budget deficit for 2020-2021 will be in the region of £3.9 million, rising to £20 million over the medium term period to 2023-2024.
4. That it is anticipated that the additional adult and children's social care grant will be sufficient to meet the projected remaining budget deficit in 2020-2021 and therefore enable the Council to set a balanced budget in that year.
5. That due to the uncertainty over the medium term, the overall level of risk associated with the 2020-2021 Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024 is assessed as Red.
6. That an element of the high-level strategy for 2020-2021 relate to one-off opportunities that can be achieved in 2020-2021.
7. That the updated projected deficit assumes the achievement of previously approved budget reduction and income generation proposals amounting to £9.6 million over period 2019-2020 to 2023-2024.
8. That the 2020-2021 budget timetable will, as in previous years, include an update on all budget assumptions and the Provisional Local Government Settlement which will be presented to Cabinet in January 2020, with the final budget report due to be approved by Full Council in March 2020.

## **1.0 Purpose**

- 1.1 The purpose of this report is to provide Councillors with an update on progress towards identifying additional budget reduction proposals in order to address the projected budget deficit of £4.9 million in 2020-2021 and budget challenge over the medium term to 2023-2024.
- 1.2 This is the second report of the financial year on the Draft Budget and the Medium Term Financial Strategy (MTFS) for the period of 2020-2021 to 2023-2024.

## **2.0 Background and Summary**

- 2.1 Since 2010-2011 despite the successive cuts in Council resources, which have led to significant financial challenges, the Council has set a balanced budget in order to deliver vital public services and city amenities. Over the last eight years the Council has identified budget reductions in excess of £220 million. The extent of the financial challenge over the medium term continues to represent the most significant challenge that the Council has ever faced, with reducing resources, growing demand for services and significant cost pressures.
- 2.2 In order to respond to this financial challenge and the growing demand for services, the Council has developed a Five Year Financial Strategy to address the projected deficit over the medium term which is detailed in section 3 of this report.
- 2.3 The Council's General Fund Balance stands at £10 million, which is the minimum balance as determined in the Council's Reserves and Balances Policy. In addition, the Council holds specific reserves which are set aside to fund future planned expenditure. It is vital the Council continues to hold these reserves to mitigate the risk of uncertainty of any potential future expenditure and therefore it is not an option to use the funds to meet the budget deficit.
- 2.4 The Budget and Medium Term Financial Strategy (MTFS) 2019-2020 to 2023-2024 was presented to Full Council for approval on 6 March 2019. The Council was able to set a balanced budget for 2019-2020 without the use of General Fund reserves. However, it was projected that the Council would be faced with finding further estimated budget reductions totalling £27.3 million in 2020-2021 rising to £40-£50 million over the medium term to 2023-2024.
- 2.5 It is important to note that the updated projected budget deficit assumes the achievement of previously approved budget reduction and income generation proposals amounting to £9.6 million over the five-year period from 2019-2020 to 2023-2024. Having identified budget reductions in excess of £220 million over the previous eight financial years, the extent of the financial challenge over the medium term continues to represent the most significant challenge that the Council has ever faced.

- 2.6 In March 2019, Full Council approved that work started immediately to identify budget reductions and income generation proposals for 2020-2021 onwards, in line with the Five Year Financial Strategy, and for progress to be reported to Cabinet in July 2019.
- 2.7 It should be noted that due to external factors, budget assumptions remain subject to change. This could therefore result in alterations to the financial position faced by the Council.
- 2.8 An update on the draft budget strategy, linked to the Five Year Financial Strategy, including the budget reduction and income generation targets to address the projected budget challenge of £27.3 million for 2020-2021 and future years was presented to Cabinet on 31 July 2019. At that point, various opportunities including: anticipated grant income arising as a result of a one year spending announcement, council tax income, adult social care precept, capital receipts and other one-off funding streams and budget proposals linked to the Financial Strategy resulted in the identification of £22.4 million towards the projected budget deficit for 2020-2021. Cabinet approved the incorporation of high-level budget strategy for 2020-2021 into the Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024. Taking this into account, the remaining budget challenge to be identified for 2020-2021 stood at £4.9 million.
- 2.9 Work has continued during the second quarter of this financial year to identify opportunities in line with the Five Year Financial Strategy to support the budget strategy for 2020-2021 and future years, whilst also analysing the potential resources available to the Council following the Spending Round 2019 announcement on 4 September 2019.
- 2.10 This report provides an update on progress towards the budget strategy for 2020-2021 and future years, whilst also detailing emerging pressures that the Council currently faces.

### **3.0 Five Year Financial Strategy**

- 3.1 The Council's strategic approach to address the budget deficit continues to be to align resources to Our Council Plan 2019-2024 which was approved by Full Council on 3 April 2019.
- 3.2 Our Council Plan 2019-2024 sets out how we will deliver our contribution to Vision 2030 and how we will work with our partners and communities to be a city of opportunity. The plan includes six strategic priorities which come together to deliver the overall Council Plan outcome of 'Wulfrunians will live longer, healthier and more fulfilling lives.' Over the medium term, resources will continue to be aligned to enable the realisation of the Council's priorities of achieving:
  - Children and Young People get the best possible start in life
  - Well skilled people working in an inclusive economy
  - More good jobs and investment in our city
  - Better homes for all
  - Strong, resilient and healthy communities
  - A vibrant, green city we can all be proud of.

3.3 The Financial Strategy, approved by Council in March 2019, consists of five core principles underpinned by eight core workstreams. Using the Core Workstreams as the framework for the Financial Strategy detailed delivery plans are being developed all with a lead director. The Core principles and workstreams are:

- **Core Principles:**

- **Focusing on Core Business.** Focus will be given to those activities that deliver the outcomes local people need and which align to our Council Plan and Financial Strategy.
- **Promoting Independence and Wellbeing.** We will enable local people to live independently by unlocking capacity within communities to provide an effective and supportive environment.
- **Delivering Inclusive Economic Growth.** We will continue to drive investment in the City to create future economic and employment opportunities.
- **Balancing Risk.** We will ensure we base decisions on evidence, data and customer insight.
- **Commercialising our Approach.** We will boost social value in our City by maximising local procurement spend with people and businesses.

- **Core Workstreams:**

- **Promoting Digital Innovation.** Improve access to digital services to empower local people to self-serve at a time and place that suits them whilst reducing 'traditional' operating costs.
- **Reducing demand.** Through early intervention and closer collaboration with local people we aim to reduce demand for services and support greater independence and resilience.
- **Targeted Service Delivery.** Our efforts will be focused in the areas and places that need us the most and where we can deliver the best possible outcomes within the resources available.
- **Sustainable Business Models.** We will develop the most efficient and effective services possible, within the significant financial constraints we face, to meet the needs of local people.
- **Prioritising Capital Investment.** Aligned to our strategic plan, investment will focus on the priorities that deliver the best possible return and outcomes for local people.
- **Generating Income.** Better understanding the markets we operate in will enable us to develop new, innovative income generation opportunities with partners where appropriate.
- **Delivering Efficiencies.** By reviewing our resources, business processes and better using technology, we will deliver services which meet customer needs efficiently and cost-effectively.
- **Maximising Partnerships and External Income.** We will take a much more strategic role, working with our partners, to identify opportunities to collaborate, share resources, reduce costs and seize funding opportunities.

## 4.0 Budget Strategy 2020-2021 to 2023-2024

### Spending Round 2019

- 4.1 On 31 July 2019, Cabinet were asked to note the uncertainty regarding future funding streams for local authorities over the forthcoming Comprehensive Spending Review period. At that point, it was unclear as to whether the Comprehensive Spending Review 2020, and the corresponding reforms to the Fair Funding Formula and Business Rates Retention, would be announced in this financial year in order to provide greater certainty for 2020-2021 and the medium term.
- 4.2 Cabinet were also informed that the Local Government Association and financial research organisations envisaged that the Comprehensive Spending Review 2020 would be delayed due to the extension of ongoing negotiations surrounding Brexit and the Leadership election process for a new Prime Minister, and therefore local authorities would be likely to receive a one-year settlement for 2020-2021 only.
- 4.3 On 4 September 2019, the Government announced the Spending Round 2019 which set out the Government's spending plans for 2020-2021 only.
- 4.4 As anticipated, it was confirmed that the full multi-year Spending Review will take place in 2020 for funding post 2020-2021. The review will take into account the nature of Brexit and set out further plans for long term reform. It is envisaged that the Fair Funding Review and Business Rates Retention reforms will be addressed as part of the multi-year Spending Review.
- 4.5 The report to Cabinet on 31 July 2019 clarified that a number of assumptions had been made with regards to the level of resources that will be available to the Council. Whilst there continues to be a considerable amount of uncertainty regarding future funding streams for local authorities over the medium term, the following paragraphs detail the Spending Round 2019 announcements which impact on the Council's Medium Term Financial Strategy.

## 5.0 Corporate Resources

### Council Tax assumptions

- 5.1 The Draft Budget and Medium Term Financial Strategy (MTFS) 2020-2021 to 2023-2024 report presented to Cabinet on 31 July 2019 indicated that additional funds in the region of £1.0 million could be realised in 2020-2021 if council tax were to be raised by an additional 1% to 2.99%. Furthermore, if the adult social care precept were to be increased by 2% in 2020-2021 additional funds in the region of £2.1 million would be available to support the delivery of key Adult Services.
- 5.2 In the Spending Round 2019, the Government announced that they will consult on providing local authorities with adult social care responsibilities the power to raise an additional 2% via the adult social care precept in 2020-2021. Should this power be granted, it would enable councils to raise further funding to support adult social care. As

detailed in paragraph 5.1, the additional 2% adult social care precept is in line with the Council's assumptions.

- 5.3 In addition to this, the Government are consulting on a core council tax referendum limit of 2% for 2020-2021. As detailed in paragraph 5.1, the MTFS currently assumes that total council tax income in the region of £100.1 million would be available to the Council if a 2.99% council tax increase were approved for 2020-2021. In order to be prudent, it is proposed that the Council's MTFS assumptions be revised downwards to reflect a 1.99% increase in council tax in 2020-2021; therefore, resulting in a budget pressure totalling £1.0 million in 2020-2021.
- 5.4 In line with Cabinet approval of the draft budget strategy in July 2019, the Council will continue to consult with residents on increasing council tax up to 2.99% and increasing the adult social care precept by 2% in 2020-2021. This will therefore enable the Council to consider increasing council tax and adult social care precept should additional flexibility be granted during the 2020-2021 Local Government Finance Settlement. A review of the council tax base, that is the number of properties in the city, will be presented to Cabinet as part of the 'Council Tax Base and Business Rates Net Rate Yield' report in January 2020.

#### **Social Care Grants**

- 5.5 The Government announced that additional grant funding totalling £1 billion would be made available to local authorities in 2020-2021 for adults and children's social care, to support the rising demand on the social care system. At this stage, the proposed formula for distribution of the grant and indicative funding allocations have been released for consultation by the Ministry of Housing, Communities and Local Government (MHCLG). The outcome of the consultation will be confirmed in the provisional settlement in December.
- 5.6 This additional funding is in addition to the existing adults and children's social care grants that have been received in 2019-2020; which the Government have now confirmed will be rolled forward into 2020-2021.
- 5.7 The Government have stated that they remain committed to putting adult social care on a fairer and more sustainable footing and will bring forward proposals in due course.
- 5.8 The Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024 presented to Cabinet on 31 July 2019 assumed that the Government would announce that local authorities receive adult social care winter pressures grant funding in 2020-2021 and each year over the medium term totalling £1.4 million annually.
- 5.9 The incorporation of the roll forward of one-off grants that have been received in 2019-2020 but not previously assumed in the MTFS for 2020-2021 totals £4.3 million.

### **Public Health Grant**

- 5.10 The Government have confirmed a real term increase to the Public Health grant budget in 2020-2021 to ensure local authorities can continue to provide prevention and public health interventions. The additional funds will support the provision of public health and wellbeing across the City.

### **Business Rates**

- 5.11 Furthermore, the Government have also confirmed that business rate baseline funding levels will increase in line with inflation, which is in line with our assumptions in the MTFS. The September consumer price inflation rate has not yet been released, however it is forecast that the business rates multipliers will increase by 2%.

### **Other funding announcements**

- 5.12 In addition to the funding announcements detailed above which have a direct impact on the Council's MTFS, there were other Spending Round 2019 announcements which will provide benefits to the residents of Wolverhampton.
- 5.13 The Government has committed to increase funding for education and skills nationally over the period to 2022-2023 by £7.1 billion, when compared to 2019-2020 funding levels. The additional funding includes an allocation to support children and young people with special educational needs and further education funding. At this stage, the announcement has been made at a national level and we are therefore not aware of the specific grant allocation that will be made available for Wolverhampton.
- 5.14 Furthermore, the Government have also announced an increase in funding to help reduce homelessness and rough sleeping. Similarly, this has been announced at a national level and therefore we are not currently aware of the allocation for Wolverhampton.
- 5.15 Whilst the Spending Round 2019 announcement has provided some clarity for 2020-2021, it is important to note that the Council continues to face significant uncertainty over the medium term and it is particularly challenging to project the potential resources that will be available to the Council over the forthcoming multi-year Spending Review period. It is important to note that, any reduction in the Government's allocation of funding to the Council would have a significant detrimental impact and further increase the budget deficit forecast over the medium term.

## **6.0 One-off funding sources**

- 6.1 Work has continued during the second quarter of this financial year to identify one-off funding opportunities to support the budget strategy for 2020-2021 and future years. The various opportunities are detailed in the paragraphs below.
- 6.2 On 18 June 2019, Cabinet (Resources) Panel received a report detailing the final outturn on the Collection Fund for 2018-2019 which consisted of a cumulative surplus in the region of £1.4 million on Council Tax and a cumulative deficit in the region of £539,000 on Business Rates. Of the accumulated surplus on the Collection Fund, the Council will

retain a surplus of £960,000. When forecasting the estimated outturn on the Collection Fund for 2018-2019, it was projected that the Council would retain a deficit of £34,000. It is therefore proposed that the additional benefit arising from the positive outturn on the Collection Fund be recognised in the MTFS.

- 6.3 In addition to this, it is proposed that one-off funds totalling £1 million be released from the Job Evaluation reserve in 2020-2021. This reserve was created to fund legal costs associated with Job Evaluation. A review of the anticipated future costs indicates that this reserve can be reduced.
- 6.4 Furthermore, following the review of the anticipated costs of Job Evaluation, it is also proposed that £500,000 be released from the Equal Pay Provision in 2020-2021. The Equal Pay Provision was created to provide for any potential Equal Pay claims that could arise in the six year period post implementation of Single Status; which was on 1 April 2013. Whilst there are some claims which are yet to be resolved, it is anticipated that the remaining provision will not be required in its entirety.

## **7.0 Update on Emerging Factors and the Budget Challenge for 2020-2021**

- 7.1 The assumptions used in the preparation of the budget and Medium Term Financial Strategy (MTFS) remain under constant review and update.
- 7.2 In July 2019, Cabinet were informed of emerging pressures within Adult Services following a fee review and demographic pressures in 2019-2020.
- 7.3 In addition to this, potential cost pressures within the Waste and Recycling Service were highlighted if a restructure within the service were to take place where employees not currently on NJC terms and conditions of employment could result in them being employed on this basis; item 12 - 'Waste Transformation Programme - Future Service Delivery Arrangements' on the agenda for this meeting provides further details on the proposals.
- 7.4 These service areas continue to be kept under review, however in order to be prudent, it is proposed that budget pressures in the region of £4.7 million prevalent in 2020-2021 are recognised, therefore increasing the projected budget deficit in that year as detailed in Table 1 overleaf.
- 7.5 In July, Cabinet approved that alternative funding sources would be sought to fund the Wolves at Work Programme to reduce the cost to the Council whilst protecting this successful initiative. At this time alternative funding has not been secured however work will continue and updates will be brought to Cabinet in the next budget report. If alternative funding is not found this will increase the deficit position for 2020-2021.
- 7.6 Taking into account the forecast changes to corporate resources and emerging pressures, detailed in the paragraphs above, it is anticipated that the projected remaining budget deficit for 2020-2021 will be in the region of £3.9 million, rising to £20 million over the medium term period to 2023-2024.

**Table 1 – Draft Budget Strategy 2020-2021**

	<b>2020-2021</b> <b>£000</b>
<b>Projected Budget Challenge as at July 2019</b>	<b>4,897</b>
<b>Changes to Corporate Resources</b>	
Council Tax – reduced to 1.99%	1,045
Adult Social Care Grant (Improved Better Care Fund)	(1,947)
Additional Adult and Children's Social Care Grant	(2,351)
Collection Fund Surplus	(960)
Use of Job Evaluation Reserve	(1,000)
Release of Equal Pay Provision	(500)
<b>Potential Pressures</b>	<b>4,700</b>
<b>Revised Budget Challenge as at October 2019</b>	<b>3,884</b>

- 7.7 As detailed in paragraph 5.5, the Government have announced that additional grant funding totalling £1 billion will be made available to local authorities in 2020-2021 for adults and children's social care, to support the rising demand on the social care system. The Local Government Finance Settlement 2020-21 technical consultation, issued by the Ministry of Housing, Communities and Local Government (MHCLG), provides the proposed formula for the distribution of the grant and indicative local authority allocations of the additional unringfenced grant funding. It is anticipated that the additional adult and children's social care grant will be sufficient to meet the projected remaining budget deficit in 2020-2021 and therefore enable the Council to set a balanced budget in that year. It is important to note however, that there is no certainty around the level of funding at the point of writing. Any reduction in the Government's allocation of funding to the Council would have a significant detrimental impact and further increase the budget deficit forecast over the medium term. It is hoped that further clarity is provided in the provisional local government settlement 2020-2021, which it is anticipated will be announced in December 2019.
- 7.8 Due to the uncertainty about the additional adult and children's social care grant funding work will continue to identify efficiencies in order to reduce the budget deficit over the medium term and mitigate the reliance on one-off funding.
- 7.9 Due to external factors, budget assumptions remain subject to significant change, which could, therefore, result in alterations to the financial position facing the Council. At the point of writing, the negotiations surrounding Brexit are ongoing and there continues to be speculation around Parliamentary changes; the announcements made in the Spending Round 2019 therefore hold an element of risk.
- 7.10 **Pension deficit**

Work is being undertaken by the West Midlands Pension Fund through the triennial valuation process to determine the employer contributions that will be required over the medium term. At this stage, the MTFS reflects the forecasts based on the previous valuation in 2016. Updates will be provided to Cabinet in future reports.

#### 7.11 **Pay Award**

The MTFS assumes an average pay award of 2% per annum. National pay negotiations are likely to take a number of months to conclude. Any increase above an average of 2% will place additional pressure on the MTFS.

### 8.0 **Budget Proposals for 2020-2021**

- 8.1 In July 2019, a number of proposals were presented to Cabinet for approval to address the projected budget deficit for 2020-2021 and the medium term. Since the last update to Cabinet, further detailed work has continued to take place to develop the proposals reported to Cabinet at that point in time. As a result of this detailed work, it is anticipated that there could be potential revisions to the phasing of some budget proposals over the medium term. This will be kept under review over the forthcoming months and in the event that rephasing of proposals are required, they will be presented in future reports to Cabinet.
- 8.2 Where proposals have a 2020-2021 budget reduction or income generation target, further details for individual proposals are available on the Council's website using the following link [www.wolverhampton.gov.uk/financialstrategy](http://www.wolverhampton.gov.uk/financialstrategy)
- 8.3 For those proposals which do not impact on the 2020-2021 budget, further details for individual proposals will be made available in future reports to Councillors.
- 8.4 Directors and Heads of Service will continue to develop budget reduction and income generation opportunities for the medium term, in order to ensure that a balanced budget can be set in each individual year.

### 9.0 **Budget Risk Management and Timetable**

- 9.1 A summary of the 2020-2021 budget setting process timetable is detailed in the Table 2.

**Table 2 – Budget Timetable**

Milestone	Deadline
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Draft Budget and Medium Term Financial Strategy (MTFS) 2020-2021 to 2023-2024 report to Cabinet	16 October 2019
Formal Budget Consultation and Scrutiny	21 October – 31 December 2019
Report to Cabinet following the Provisional Local Government Finance Settlement	22 January 2020
Final Budget Report 2020-2021 to Cabinet	19 February 2020
Full Council Approval of Final Budget 2020-2021	4 March 2020

- 9.2 As detailed above the budget consultation process will take place from 21 October to 31 December 2019. This consultation process is the start of continuous engagement with the community throughout the year through community events. The Council will explore the use of digital tools to widen community engagement, however the focus will be on priorities for the City.
- 9.3 Cabinet approval is sought to delegate authority to the Cabinet Member for Resources in consultation with the Director of Finance, to approve the final budget consultation arrangements.
- 9.4 The overall level of risk associated with the Draft Budget and Medium Term Financial Strategy (MTFS) 2020-2021 to 2023-2024 is assessed as Red. The following table provides a summary of the risks associated with the MTFS, using the corporate risk management methodology.

**Table 3 – General Fund Budget Risks 2020-2021 to 2023-2024**

Risk	Description	Level of Risk
Medium Term Forecasting	Risks that might materialise as a result of the impact of non-pay inflation and pay awards, uptake of pension auto enrolment, and National Living Wage.	Amber
Service Demands	Risks that might materialise as a result of demands for statutory services outstretching the available resources. This particularly applies to adults and children's social care.	Red
	Risks that might materialise as a result of demands for non-statutory services outstretching the available resources.	Amber
Identification of Budget Reductions	Risks that might materialise as a result of not identifying budget reductions due to limited opportunity to deliver efficiencies.	Amber

Budget Management	Risks that might materialise as a result of the robustness of financial planning and management, in addition to the consideration made with regards to the loss of key personnel or loss of ICTS facilities	Green
Transformation Programme	Risks that might materialise as a result of not delivering the reductions incorporated into the budget and not having sufficient sums available to fund the upfront and one-off costs associated with delivering budget reductions and downsizing the workforce.	Amber
Reduction in Income and Funding	Risks that might materialise as a result of the multi-year Spending Review, which is due to be announced in 2020-2021, and reforms to Business Rates Retention and the Fair Funding Review.	Red
	Risks that might materialise as a result of income being below budgeted levels, claw back of grant, or increased levels of bad debts.  The risk of successful appeals against business rates.	Amber
Third Parties	Risks that might materialise as a result of third parties and suppliers ceasing trading or withdrawing from the market.	Amber
Government Policy	Risks that might materialise due to structural uncertainties including the impact of exiting the European Union.	Red
	Risks that might materialise as a result of changes to Government policy including changes in VAT and taxation rules, and in particular, from the Care Bill.	Red

## **10.0 Evaluation of alternative options**

- 10.1 In determining the proposed Five Year Financial Strategy, consideration has been made to the deliverability of budget reduction and income generation proposals and budget pressures. If we were to not implement the budget strategy as proposed in this report, alternative options would need to be identified in order for the Council to set a balanced budget for 2020-2021. This may therefore potentially impact upon service provision.

## **11.0 Reasons for decisions**

- 11.1 It is recommended that the budget strategy for 2020-2021, including changes to corporate resources assumptions, emerging budget pressures and budget reduction and income generation opportunities, as set out in this report, is approved by Cabinet for budget consultation and scrutiny where necessary. Cabinet will be provided with an update following formal budget consultation and scrutiny in the Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024 report which will be presented to Cabinet in February 2020. In approving this strategy, the Council will be working towards identifying options to be able to set a balanced budget for 2020-2021.

## **12.0 Financial Implications**

- 12.1 The financial implications are discussed in the body of the report.

[MH/08102019/W]

## **13.0 Legal Implications**

- 13.1 The Council's revenue budgets make assumptions which must be based on realistic projections about available resources, the costs of pay, inflation and service priorities and the likelihood of achieving any budget reduction proposals.
- 13.2 The legal duty to spend with propriety falls under S.151 Local Government Act 1972 and arrangements for proper administration of their affairs is secured by the S.151 Officer as Chief Financial Officer.
- 13.3 Section 25 of the Local Government Act 2003 requires the Chief Financial Officer to report to the Council when it is making the statutory calculations required to determine its Council Tax. The Council is required to take this report into account when making its budget decision. The Chief Financial Officer's report must deal with the robustness of the budget estimates and the adequacy of the reserves for which the budget provides. Both are connected with matters of risk and uncertainty. They are inter-dependent and need to be considered together. In particular, decisions on the appropriate level of Reserves should be guided by advice based upon an assessment of all the circumstances considered likely to affect the Council.
- 13.4 The relevant guidance concerning reserves is Local Authority Accounting Panel Bulletin 77, issued by CIPFA in November 2008. Whilst the Bulletin does not prescribe an appropriate level of reserves, leaving this to the discretion of individual authorities, it does set out a number of important principles in determining the adequacy of reserves. It emphasises that decisions on the level of reserves must be consistent with the Council's MTFS, and have regard to the level of risk in budget plans, and the Council's financial management arrangements (including strategies to address risk).
- 13.5 In addition, Section 114 of the Local Government Finance Act 1988 requires the Chief Financial Officer to '**...make a report ... if it appears to her that the Authority, a**

**committee or officer of the Authority, or a joint committee on which the Authority is represented':**

- a. has made or is about to make a decision which involves or would involve the Authority incurring expenditure which is unlawful,
  - b. has taken or is about to take a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency on the part of the Authority, or
  - c. is about to enter an item of account the entry of which is unlawful.
- 13.6 The Chief Financial Officer of a relevant Authority shall make a report under this section if it appears to her that the expenditure of the Authority incurred (including expenditure it proposes to incur) in a financial year is likely to exceed the resources (including sums borrowed) available to it to meet that expenditure.
- 13.7 These statutory requirements will have to be taken into account when making final recommendations on the budget and council tax requirement for 2020-2021.  
[TS/07102019/Q]

**14.0 Equalities implications**

- 14.1 The method by which the MTFS for 2020-2021 is developed is governed by the Council Plan priorities described in paragraph 3.2 which itself was guided by consultation and equality analysis. The further development of the various budget proposals for Cabinet's consideration will include an initial equalities screening for each proposal and, where necessary, a full equalities analysis.
- 14.2 The Council will publish details of its income generating and budget reduction proposals as part of its public consultation around the 2020-2021 budget. No proposal will be approved until the details of the responses to public consultation have been analysed for their impact on equalities. The resulting and final report to Cabinet and Council will contain a supporting equality analysis that will offer information across the whole range of proposals and will include any relevant details from the consultation work findings. The final report will enable Councillors to discharge their duty under Section 149 of the Equality Act 2010.

**15.0 Climate change and environmental implications**

- 15.1 There are no relevant climate change and environmental implications arising from this report.

**16.0 Health and Wellbeing Implications**

- 16.1 There are no relevant health and wellbeing implications arising from this report.

**17.0 Corporate Landlord Implications**

17.1 There are no relevant corporate landlord implications arising from this report.

## **18.0 Human resources implications**

- 18.1 In line with the Council's statutory duties as an employer under the Trade Union Labour Relations (Consolidation) Act 1992, an HR1 form was issued to the Secretary of State for Business, Innovation and Skills identifying the intention to reduce employee numbers by up to 500 across the Council in the period 1 April 2019 up to 31 March 2020. The reductions will be through both voluntary redundancy and budget reduction targets which could result in compulsory redundancies.
- 18.2 The numbers included in an HR1 include posts held by colleagues who, as part of business review, redesign and/or restructure, need to be included, as they will need to be put at risk of redundancy. However, many of these employees will apply and be offered jobs in the new structure or elsewhere in the organisation and therefore the number of employees leaving the authority is anticipated to be far fewer than the number declared on an HR1.
- 18.3 A new HR1 will need to be issued with effect from 1 April 2020 to 31 March 2021, on the same basis as the previous one.
- 18.4 Many of the budgetary reductions will be made through efficiencies with new and smarter ways of working and transformation initiatives. Income generation will also be key.
- 18.5 If any reductions in employee numbers are required, these will be achieved in line with the Council's HR policies. Compulsory redundancies will be mitigated as far as is possible through seeking voluntary redundancies in the first instance, and through access to redeployment.
- 18.6 The Council will ensure that appropriate support is made available to employees who are at risk of and selected for redundancy. The Council will work with partner and external agencies to provide support. If any of the budget reduction targets are to move service delivery from direct Council management to private, community or third sector providers may have implications under the TUPE regulations. If TUPE were to apply, appropriate consultation with relevant Trade Unions and affected employees, would take place.
- 18.7 The Council will consult with the recognised Trade Unions on any proposals relating to revisions to NJC terms and conditions of employment.
- 18.8 There is on-going consultation with the trade unions on the impact of the Council's budgetary position and the targets being made to meet the challenges posed by it.

## **19.0 Schedule of Background Papers**

This report is PUBLIC  
[NOT PROTECTIVELY MARKED]

Cabinet, 31 July 2019 - [Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024](#)

Full Council, 6 March 2019 - [Final Budget Report 2019-2020](#)

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# Annual Report Summary 2018/19

Agenda Item No.6

# Wolverhampton CCG

## What we did in 2018/19

This is a summary of the key work done by Wolverhampton CCG during 2018/19. You can find a full annual report, including financial accounts, on our website.

<https://wolverhamptonccg.nhs.uk/>



# Our clinical leaders



Dr D Bush



Dr J Parkes



Dr M Asghar



Dr M Kainth



Dr R Rajcholan



Dr R Gulati

# Chair's foreword

## Welcome to the 2018/19 Annual Report Summary.

I am very proud to report how our pioneering achievements have led to significantly improved care for our patients in Wolverhampton. Our member practices continue to embrace new and innovative ways of working and the results have been outstanding.

Yet again our commitment to patients in Wolverhampton was recognised by NHS England when we were awarded an 'Outstanding' rating in their 2018/2019 annual assessment. This is the highest possible rating by NHS England and the fourth consecutive year that the CCG has been recognised as 'Outstanding'. This puts Wolverhampton in the top 1.5% of CCGs nationally over that period.

I am delighted to report that over 24,000 extra appointments were made available this year at four hubs in different geographical locations in Wolverhampton. Patients can now access a GP when they need to, particularly at those times an urgent same-day appointment is required without having to resort to urgent and emergency care services. It also means more people will be seen and treated closer to home in their own community. Appointments are available from 6:30pm – 8:00pm on Monday to Friday and access is also provided on Saturdays, Sundays and Bank Holidays.

Another key highlight is our major uplift in NHS Health Check performance from the lowest quartile to the top tier of performers nationally. The NHS Health Check is playing an important role in the prevention and early detection of cardiovascular disease. This work, in collaboration with public health, has seen the number of eligible adults who have received a health check rise from 11% to 41%. We have enabled practices to really scale up their provision of health checks and we have performed almost three times as many health checks across the City this year compared to our last financial year.

Achieving these excellent results has only been possible through the collaborative working arrangements between primary care practices. This means we are ideally placed to make a success of the Primary Care Networks (PCNs) that form a key part of the NHS Long Term Plan. A key benefit of PCNs is to offer more personalised, coordinated health and social care to their local populations. In Wolverhampton we have already strengthened the working relationships between GPs, acute and community services so that patients benefit from seamless and consistent patient care. All the work that we have done in transforming primary care will enable us to have PCNs in place swiftly and effectively.

We continue to make significant strides forward in our journey towards an Integrated Care System (ICS) across the Black Country and West Birmingham. In addition, we are developing our Integrated Care Alliance (ICA). This is a collaborative working between primary care, our acute and community trust, public health, the mental health trust and the local authority. I can report that strong progress has been made in improving integrated care around frailty, mental health, children and young people and end of life for the whole of Wolverhampton.

During the last year, I have been privileged through my leadership programme at Kings Fund, to meet with many inspirational colleagues across the country who are making a real difference to patients with their own integrated care systems which we can certainly learn from. It's important that we all share best practice and we are working closely together with our partners in the Black Country and West Birmingham, where demand for health and care services is growing and evolving.

Our CCG is playing a pivotal role in the development of joint working across the Black Country and West Birmingham STP to ensure that we secure the best possible care for the people of Wolverhampton. In April 2018, Dr Helen Hobbs, our Accountable Officer, took over the reins as Senior Responsible Officer for the STP. Our executive Steven Marshall is leading on mental health, Sally Roberts is lead nurse for the STP and its Clinical Leadership Group, Mike Hastings is the IT & Digital Lead and I am heading up the Black Country Joint Commissioning Committee. We are making strong headway in developing approaches to closer working with the other CCGs in the Black Country to commission services across the STP footprint.

Making better choices today can have a big impact on our health and I have been working with our communications team to ensure that local people have the key information they need to stay in good health throughout the year. Our PR campaigns included winter, self-care, diabetes, bowel cancer awareness and Play your Care Right.

The NHS 70 celebrations last July were an important reminder of the key role that the NHS plays in all our lives. This was brought home to me when a spell of ill health resulted in me experiencing at first hand the extraordinary care that our NHS staff deliver.

I would personally like to thank our dedicated CCG staff for the outstanding work they do every day to make sure people in Wolverhampton receive the best possible care. This includes our communications and engagement team who have been actively working with patients to obtain their views and feedback on the improvements we have introduced. A special thank you also goes to our hard-working GPs and member practice teams and for their active participation in all the pioneering schemes aimed at transforming patient care. Finally, thank you to all our patients and patient groups who have worked with us to ensure that local health care continues to develop and meet the needs of the population we serve.



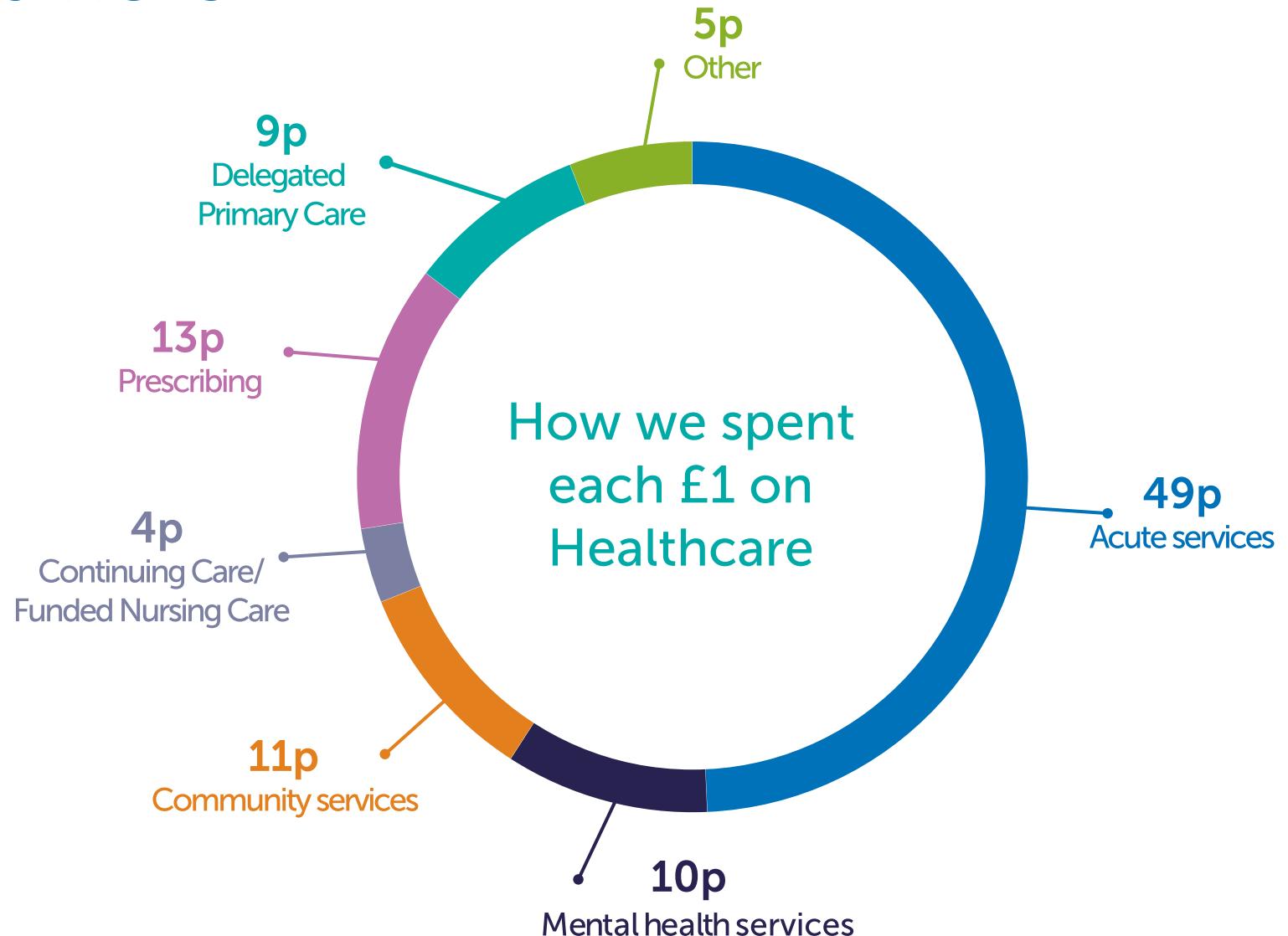
**Dr Salma Reehana**  
**Clinical Chair**

# Money Matters

Our total budget for the year was £414.050m (excludes surpluses brought forward). The total budget included £5.560m to run the CCG. Overall, we managed to stay within the money that was allocated to the CCG.

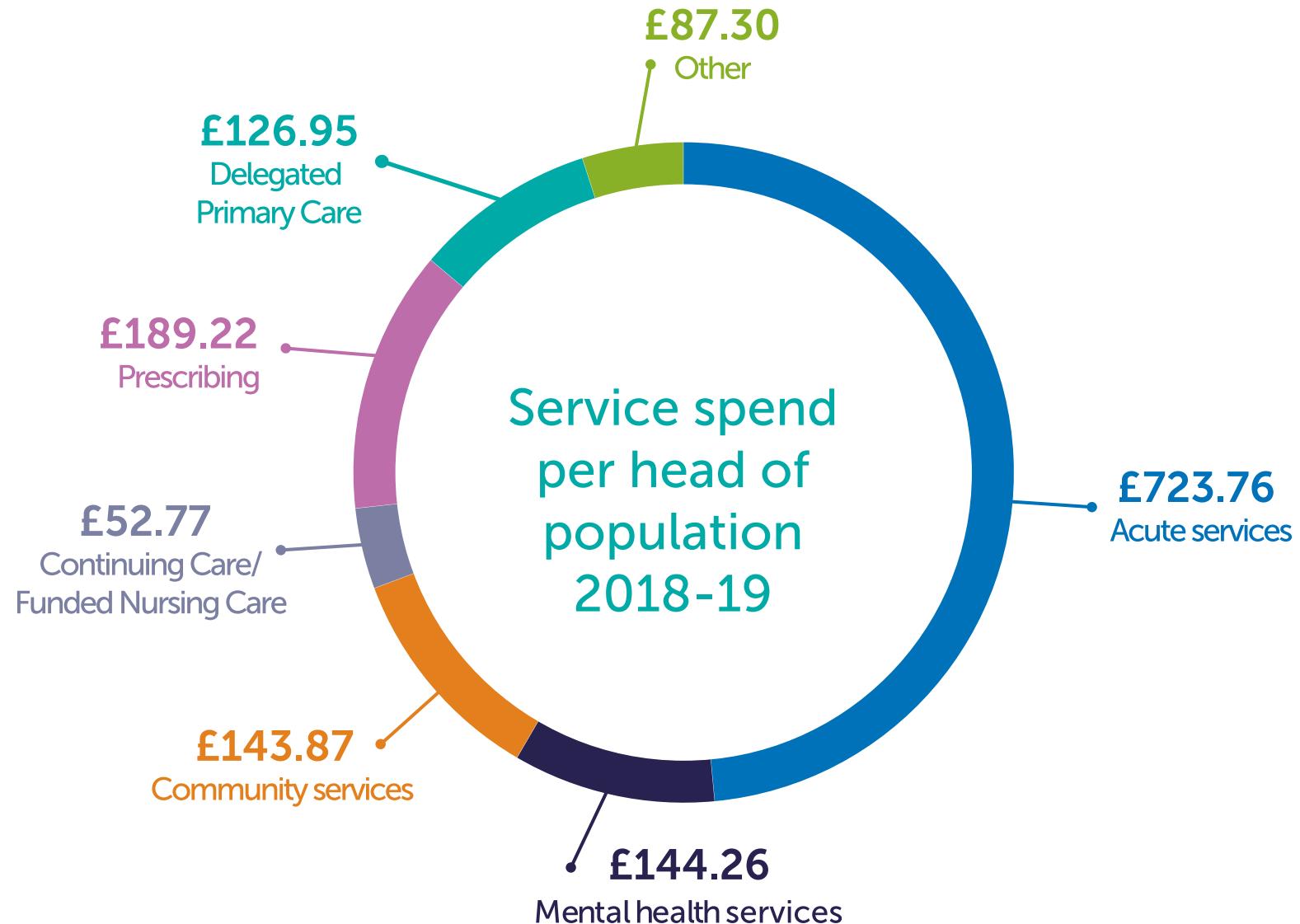
Page 38

We did overspend on some things, hospital services mainly due to increased emergency admissions and mental health services mainly due to complexity of cases but these were offset by underspends in other areas.



In 2018-19 the CCG spent £1,468 per person on providing healthcare services to people registered with a WCCG practice.

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## Primary care

Over the last year, the CCG has worked hard to improve access to primary care and deliver quality services for patients in Wolverhampton. Our member GP practices have continued to embrace new ways of working which has led to innovative improvements in primary care.

While we recognise that there is still work to do, we are proud of what we have achieved in the last year.

## Services at scale

In Wolverhampton our GP practices have been working together for some years. This year, they have started to work even more collaboratively through the formation of Primary Care Networks (PCNs). These are groups of practices who work together, at scale, to make general practice more resilient and improve patient experience. Through sharing resources, practices can provide a wider range of services to patients and integrate more easily with the wider health and care system.

There are six PCNs in Wolverhampton and each is formed of approximately seven practices. The six PCNs are derived from the models of care previously in place. These were collaborations between GPs, established as Primary Care Homes, Medical Chambers and Vertical Integration models, each with their own partnership and data sharing agreements in place. With the inception of PCNs, the groups have built on this already established basis, entering into networks that are both geographically cohesive but also retain the partnership structures already in place.

This new way of working has led to key improvements for patients in Wolverhampton and these have been positively recognised by NHS England. These improvements include a seven day service in primary care, an additional 2,700 appointments available each month and the ability to book routine and urgent appointments within the groups.

## Care when and where you need it

We want to ensure that the right treatment is available for patients in the right place at the right time. Great importance is being placed upon patients being able to access the most appropriate professional for their needs, which is not always a GP. Our GP practice teams have expanded to include pharmacists, physician's associates, care navigators and social prescribers. This means that patients can access various types of appointments with different practice staff, depending on their need.

## Online services

The CCG has also been working to extend access to online services for patients. We have introduced a two way texting system for practices and patients to use. Reminders are sent to patients for their upcoming appointments and they can respond to say whether they can attend or not. This has led to reduced Did Not Attend rates in Wolverhampton.

Pilots are currently being undertaken to support the roll out and development of online triage and consultations.

# Working in partnership

To be effective our CCG needs to work with a range of partners to ensure we are commissioning the right services for the people of Wolverhampton. This year, we have continued to strengthen relationships with our partners and have worked collaboratively to improve health and social care outcomes for patients. We have done this by:

## Developing our Integrated Care Alliance

Over the year we have progressed our Integrated Care Alliance (ICA), which is the work that we are doing with partners across the City to keep people healthier for longer, right from birth.

 We are working with partners to develop an ICA which is the best fit for local people. We want to ensure people can access the services that they need as close to their homes as possible, relieving pressure on our acute hospitals where we can.

In January this year, a series of engagement events were held for clinicians and managers of the ICA's partner organisations including: City of Wolverhampton Council, Wolverhampton Clinical Commissioning Group, Wolverhampton Primary Care, The Royal Wolverhampton NHS Trust and Black Country Partnership Foundation Trust. The event held at The Molineux Stadium was well attended by over 70 stakeholders. Attendees heard about what the ICA will mean for the 39 organisations involved and about work beginning on the first four clinical Workstreams. These are End of Life, Frailty, Children and Young People, and Mental Health.

This work forms part of our journey towards an Integrated Care System; a new type of even closer collaboration between NHS organisations and local councils, which will see us taking joint responsibility for managing resources and improving the health and wellbeing of our population.

## Working with partners in the Black Country and West Birmingham Sustainability and Transformation Partnership

We continue to work collaboratively with partners in the Black Country and West Birmingham Sustainability and Transformation Partnership (STP), which aims to deliver sustainable, integrated health and care services that improve the health, wellbeing and prosperity of our residents.

### Key achievements over the year include:

- A new specialist perinatal mental health service that provides timely support and treatment for pregnant women and new mums
- Developing a clinical strategy with local clinicians to ensure better health, better care and better value of services
- Introducing new workforce schemes that encourage GPs to stay in the primary care workforce
- A cash injection of £79.4 million to modernise and transform NHS services and healthcare facilities across the Black Country and West Birmingham.
- We are leading on developing a digital strategy and implementation plan and overseeing the implementation of digital innovations for patients and clinicians across the whole health economy



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## Increasing access to NHS Health Checks

The NHS Health Check plays an important role in the prevention and early detection of stroke, kidney disease, heart disease, type 2 diabetes and dementia, and has been a focus for the CCG and the City of Wolverhampton Council's Public Health team this year. By working together through a new joint commissioning model, we have made it easier for GPs to identify eligible patients and, in turn, for those patients to receive a health check. Since April 2018, the number of eligible adults who have received a health check has risen from 11% to 41% and we have performed almost three times as many health checks across the City compared to our last financial year. This has seen us rise from one of the lowest performers of NHS Health Checks to the top tier of performers nationally.

## Improving flu-uptake in school children

One of the significant successes of this year's collaborative efforts has been our work with the City of Wolverhampton Council's Public Health and Communications teams, alongside The Royal Wolverhampton NHS Trust, to develop the 'flu fighters' campaign aimed at school children eligible for the flu vaccine (Reception to Year 5). The local 'flu fighters' story was circulated to 28,000 children across the City, along with a digital video sequence, to creatively engage young children and families with the importance of flu vaccination. Overall uptake in school children this year has risen from the lowest to the highest in the Black Country, and we have seen the highest improvement across every year group within the West Midlands region.



Dr Salma Reehana, Chair of Wolverhampton CCG with health and social care staff at the opening of the first community integrated hub



## NHS 70 Celebrations

5 July 2018 marked the NHS's 70th birthday and we celebrated with patients, the public and our partners by hosting a tea party at Sainsbury's St Marks.

# Developing mental health services

**We recognise that people's emotional wellbeing is just as important as their physical wellbeing and this year, we've worked with our partners to provide more support for our population.**

## Supporting new and expectant mums

A key achievement has been the implementation of a Specialist Community Perinatal Mental Health Service, which covers a critical gap in access to specialist care across the Black Country and West Birmingham footprint. The service is now fully operational and provides care and treatment to new and expectant mums experiencing severe mental health difficulties.

As the second stage of this work, we are hosting a Perinatal Mental Health Whole System programme, working with the Black Country and West Birmingham Local Maternity System. Through this, we will provide a stepped model of care to support mothers and fathers throughout the perinatal period to maintain and develop good mental health.

## Supporting people into work

This year, we have worked with the Dudley and Walsall Mental Health Partnership Trust to secure funding from NHS England to deliver employment support for patients with severe mental health conditions, on an STP footprint. Individual Placement Support is an evidence-based programme that aims to help people find and retain employment. For the service user the benefits of being in employment include an income and a greater sense of purpose and wellbeing, while for the health system there is an overall reduction in the use of primary and secondary mental health services, leading to improved efficiency and savings.

Working with our colleagues in the Black Country Partnership NHS Foundation Trust (BCPFT), the Voluntary Sector Council and the City of Wolverhampton Council, we have developed plans to deliver a Recovery College in 2019, which will support service users and carers of all mental health services to access help and support with regards to their wellbeing and future.

We are also very proud to continue to host the Thrive into Work programme for the Black Country and West Birmingham STP. The programme supports people with mental health and/or physical health difficulties into paid employment or self-employment.

## Improving access to services

Across primary and secondary care, we have worked with GPs and BCPFT to improve access to essential Physical Health Checks for people with severe and enduring mental illness. This year, we have seen the number of eligible adults who have received a health check rise from 11% to 41%.

We have extended our commissioning of Primary Care Counselling and Core IAPT (Improving Access to Psychological Therapies) services to include the delivery of online therapy via the Big White Wall and to commence our plans to deliver IAPT for people with a long-term condition. The Big White Wall is an online community for people who are stressed, anxious or feeling low. People can access the forum at any time and there is round the clock support from trained professionals.

To ensure that, wherever feasible, people from Wolverhampton can access care as close to home as possible, we have continued to work with providers and colleagues within the City of Wolverhampton Council to commission community services based care pathways and care packages that provide safe, sound and supportive care for people of all ages. At the same time, we have focussed on bringing patients closer to home where they are currently being cared for outside of Wolverhampton. This will improve patient and carer experience and outcomes, value for money and financial sustainability, and allow for re-investment in more locally based care.

## Child and Adolescent Mental Health

This year we have developed our Child and Adolescent Mental Health services (CAMHs) Transformation Plan for 2018-2020 to ensure that services across the City meet the current and future needs of our children and young people.

We have made great strides in improving the gap in provision of lower intensity emotional mental health and wellbeing services in Wolverhampton. In April 2018, we jointly commissioned a new service with the City of Wolverhampton Council and HeadStart to provide children and young people with advice and support for any concerns relating to mental and emotional wellbeing. Through the Beam Wolverhampton service, children and young people up to the age of 18 (up to the age of 25 for care leavers or anyone with a disability) have access to online resources, scheduled sessions with qualified therapists and a drop-in service where young people don't need an appointment to speak to trained staff. It is estimated that this service will support over 2,000 children and young people in our City every year.

Children and young people aged 11 to 18 can now also benefit from a new online counselling service which we launched during the year. The service, which is provided by Kooth, is a free, safe, confidential and non-stigmatised way for young people to receive counselling, advice and support online. Young people self-refer to the service via [www.kooth.com](http://www.kooth.com).

The therapy team are qualified counsellors and psychotherapists who deliver evidence-based interventions. The counsellors have clear pathways into other services and ensure the young person gains information needed and is signposted to the most appropriate provision.

# Improving quality

**Quality is at the heart of everything we do here at Wolverhampton CCG. As responsible commissioners, we are fully committed to driving quality and improvement in services, ensuring a positive patient experience and making sure all services commissioned are safe and effective.**

The of the ways we have improved quality and patient safety this year is through our Safer Provision and Care Excellence (SPACE) programme. SPACE was set up to train care home staff and managers in safety improvement techniques, with the aim of strengthening the safety culture and reducing the incidence of adverse events in care homes.

18 care homes in Wolverhampton took part in the two year programme and their achievements were recognised at an event held in November 2018. Participants came together to share their learning and best practice. Key outcomes included: low rates of harm, low A&E usage and hospital admissions, and the development of innovative care environments to improve the wellbeing of residents. One care home developed a relative's bereavement room, widowers club, tea room and hairdressing salon.

The feedback from the programme has been extremely positive and has been recognised locally and nationally. Although the two year programme

has ended, the CCG is committed to continue the work within care homes and share our best practice with others. A sustainability plan has been developed in conjunction with Walsall CCG, City of Wolverhampton Council, Continuing Health Care and acute trust colleagues to support continuation of the programme beyond December 2018.

## Improving cancer performance

During 2018/19 there have been challenges in relation to mortality performance within The Royal Wolverhampton NHS Trust. As a result of this, significant quality improvement initiatives have been implemented to drive improvement. The CCG has established a system wide Mortality Improvement Group, with good representation across the system, including Public Health and Primary Care. Data analysis has identified key areas of focus and initial indications are identifying that this is having a positive impact on mortality rates within our population.

This year, cancer performance has been impacted by increasing demand and reduced capacity. The CCG has worked collaboratively with the provider, the cancer alliance, NHS England and NHS Improvement, and across the wider Black Country system to identify initiatives to help mitigate risk for our population and improve performance. Robust processes have been developed to ensure any potential harm associated with delays are assessed and any learning identified. So far, no adverse harm has been identified as a result of the waits.

# Engaging people and communities

**We are committed to engaging with local people and communities to understand their needs and use the information we gather to improve services for our population.**

**Some highlights of the engagement activity we carried out during 2018/19 are listed below.**

**Children's services** - In June 2018 we attended a Wolverhampton SEND event to engage with parents and carers about their experiences of health services across the city. Information gathered at the event will help to shape future commissioning.

**Skin (Dermatology) services** - During January and February 2019 we asked Wolverhampton residents' views about dermatology (skin) services. We asked participants to tell us their current and past experiences, share their views and help shape the future design of community dermatology services in Wolverhampton. We held two focus groups and shared an online survey to gather opinion. We will use the feedback we received to inform the decisions we make on how community dermatology services are provided in Wolverhampton.

**Prescribing over the counter medicines** - In August 2018 we engaged with members of the public on reducing prescribing of over the counter medicines for minor, short-term health conditions.

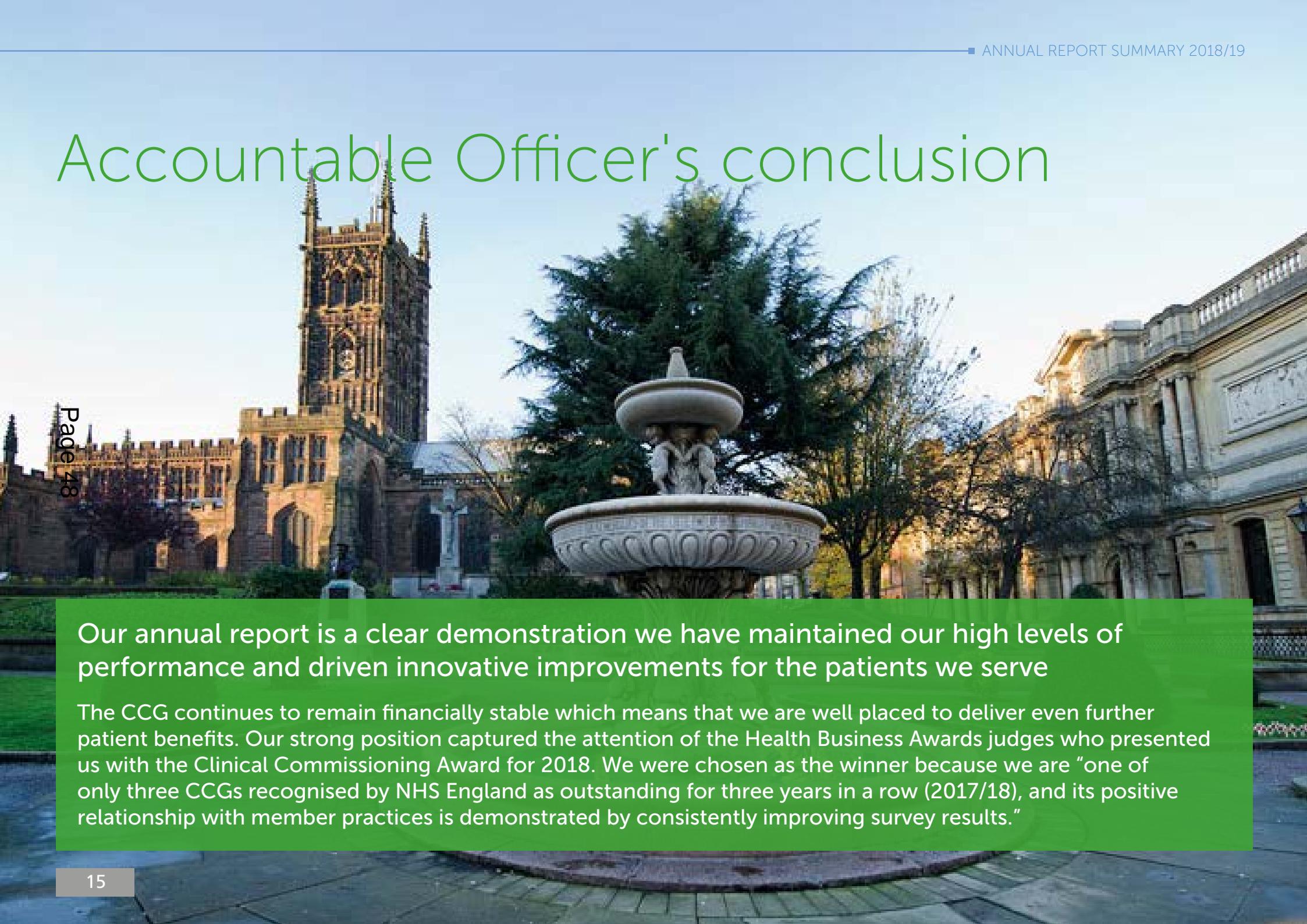
We set up a survey to ask people their views on whether medications that are available to buy over the counter should continue to be available on prescription. We promoted the survey via our online channels and attended two groups across the city to do some targeted engagement. The groups we attended were a respiratory group and an older people's group. We had 180 responses to the survey. To support and implement the changes, we have distributed posters and leaflets to GP practices to be displayed in their waiting areas.

A full list of engagement activity that took place during 2018/19 and upcoming engagement opportunities can be found on our website.



# Accountable Officer's conclusion

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Our annual report is a clear demonstration we have maintained our high levels of performance and driven innovative improvements for the patients we serve

The CCG continues to remain financially stable which means that we are well placed to deliver even further patient benefits. Our strong position captured the attention of the Health Business Awards judges who presented us with the Clinical Commissioning Award for 2018. We were chosen as the winner because we are "one of only three CCGs recognised by NHS England as outstanding for three years in a row (2017/18), and its positive relationship with member practices is demonstrated by consistently improving survey results."

**Looking back on our achievements in 2018/19, we are proud to have made a significant difference to the patient experience in Wolverhampton. Our successful partnership with our member GP practices has been vital in creating better access arrangements for patients, which includes seven day working. Patients can now access care more rapidly at a time that is more convenient for them.**

There has also been an increase over the year in our Rapid Response team of nurse practitioners who can support patients in care homes or in their own homes which means that they can receive swift treatment without going into hospital.

Our GP practice teams have expanded so that patients can now have access pharmacists, physician's associates, care navigators and social prescribers. We are also currently working on exciting initiatives such as online consultations for patients that are unable to physically attend appointments. The introduction of a two way texting system for practices and patients to use has led to reduced 'Do not attend' rates as text reminders are now sent to patients.

Improving the quality of patient care is paramount and our Safer Provision and Care Excellence (SPACE) programme has received national recognition. This two-year large-scale Care Home Quality Improvement (QI) programme has significantly improved and strengthened safety culture in care homes and improved the wellbeing of care home residents.

The launch of the BEAM Wolverhampton service will be pivotal in improving the emotional mental health and wellbeing of thousands of children and young people in Wolverhampton. The service is commissioned by our CCG in partnership the City of Wolverhampton Council and HeadStart Wolverhampton and will support over 2,000 children and young people every year.

We continue to work collaboratively with partners in the Black Country and West Birmingham Sustainability and Transformation Partnership (STP), which aims to deliver sustainable, integrated health and care services that improve the health, wellbeing and prosperity of our residents. Key achievements over the year include a new specialist perinatal mental health service, introducing new workforce schemes that encourage GPs to stay in the primary care workforce and a capital allocation of £79.4 million to modernise and transform healthcare facilities across the Black Country and West Birmingham.

The success of the local NHS70 celebrations last year was a positive demonstration that Wolverhampton people are immensely proud of the NHS and the Long Term Plan, launched in January 2019, will ensure the NHS is fit for future generations.

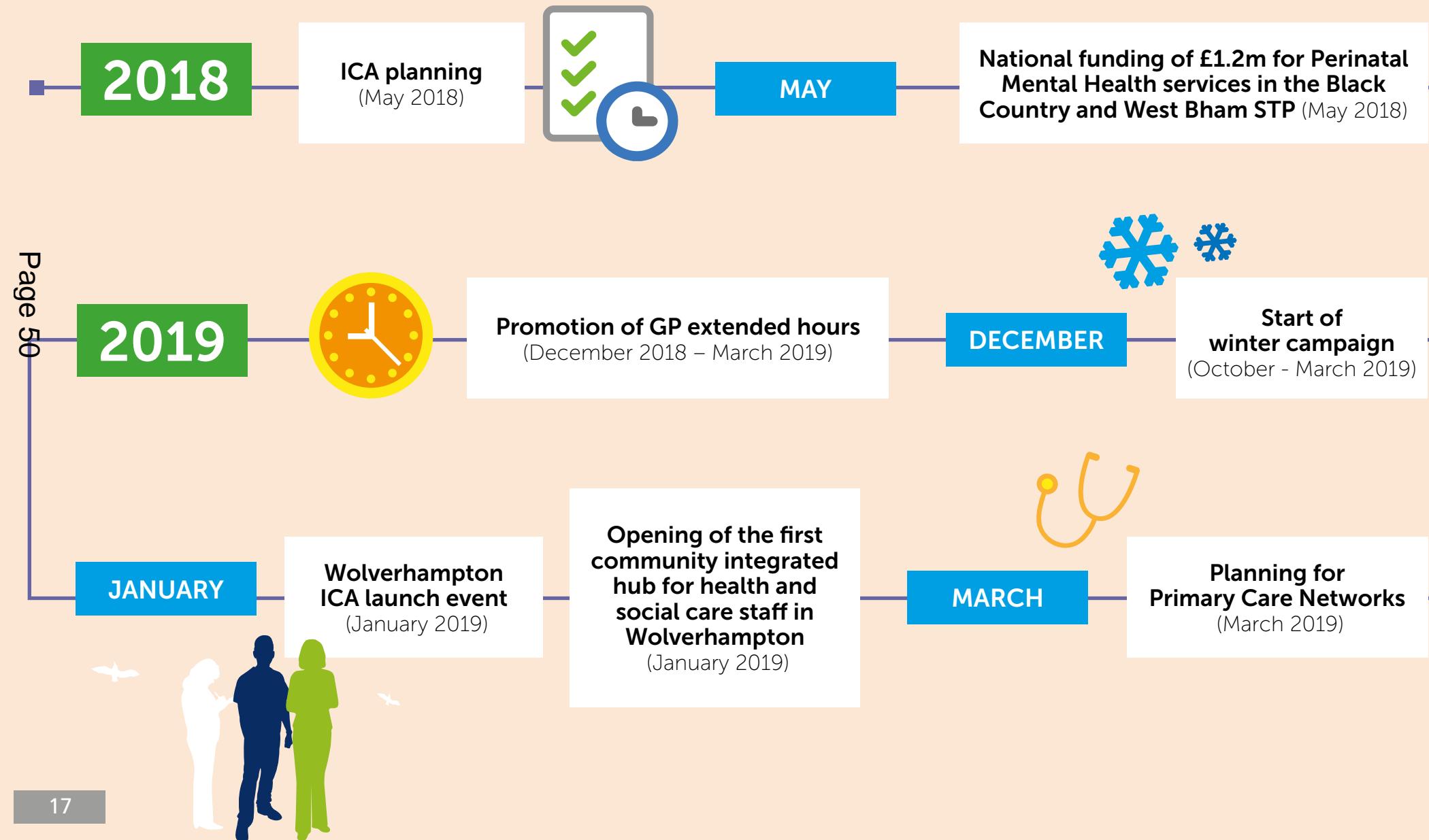
We are now working with primary, community and mental health services on our local plan for 2019/20. This will determine how we intend to take the ambitions that the NHS Long Term Plan details and turn them into local action to improve services and the health and wellbeing of our population.

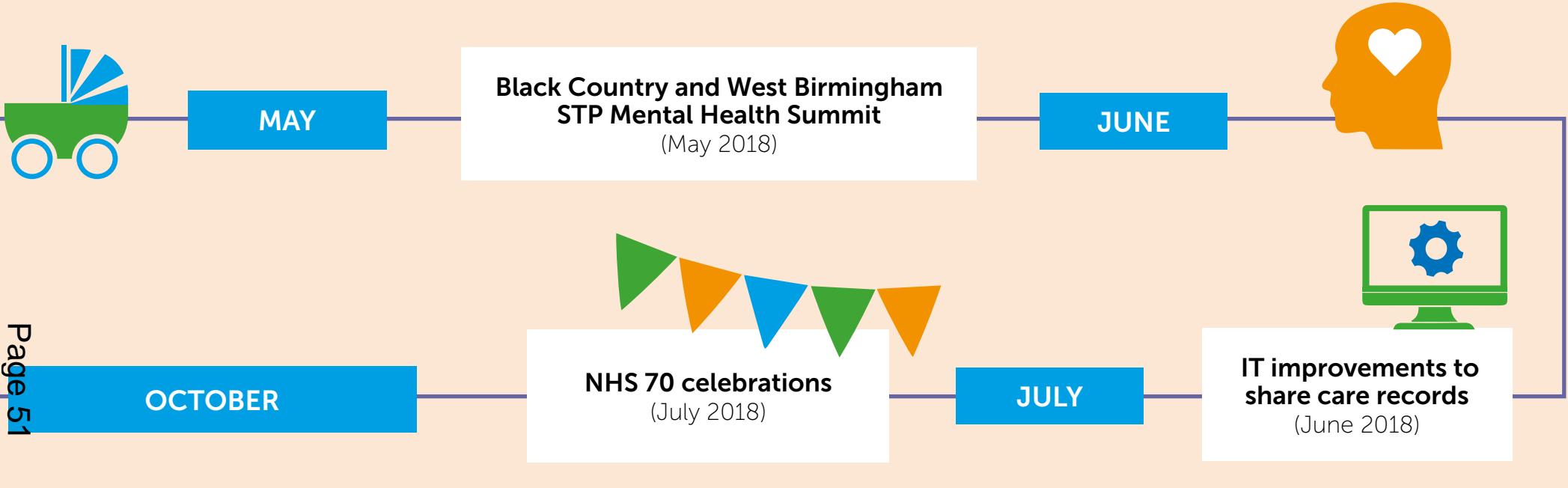
We would like to thank all our staff and all our member practices for their dedication and commitment to improving patient care and ensuring that patients remain at the heart of everything we achieve.

**Dr Helen Hibbs MBE  
Accountable Officer**



# Timeline





# Annual Report Summary 2018/19



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**Accessibility statement** - Any request for this document in another format (such as large print) or language will be considered.

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★ ★ ★ ★  
Recognised as an outstanding  
CCG four years running

2018/19

# ANNUAL REPORT



**Wolverhampton**  
Clinical Commissioning Group



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## **FOREWORD ACCOUNTABLE OFFICER**

Against the backdrop of rising costs, an ageing population and ever-increasing numbers of patients with ongoing health conditions, I am proud to report that we have delivered a strong performance and made a positive difference to healthcare for the people we serve.

Despite the increasingly difficult financial period that the NHS finds itself in, we have been able to maintain financial stability with our prudent and careful management of resources. In July 2018 we were delighted yet again to be awarded with an ‘Outstanding’ rating by NHS England (NHSE) for the third year running in their 2017/2018 annual assessment. We were the only CCG to be awarded this rating in the West Midlands and it places us in the top 1% of best performing CCGs nationally during this period.

Our strong successes captured the attention of the Health Business Awards judges who presented us with the Clinical Commissioning Award for 2018. Our CCG was chosen as the winner because we are “one of only three CCGs recognised by NHS England as outstanding for three years in a row, and its positive relationship with member practices is demonstrated by consistently improving survey results.”

Such national recognition is a strong reflection of the dynamism and dedication of our staff and GP members. We benefit from high staff retention rates and results from the latest annual NHS staff survey show our staff feel valued by the CCG and would recommend the organisation as a good place to work.

Over the last year there have been a number of exciting developments and improvements through our new models of care delivery that include a vertical integration model, two primary care homes and a medical chambers model.

Inspired by the GP Five Year Forward View, this is helping us to shape primary and community services for the future. The four groups of GPs in Wolverhampton (Wolverhampton Total Health, Wolverhampton Care Collaborative, Unity and Vertical Integration) which are made up of different GP Practices working together, have delivered key improvements for patients and these have been positively recognised by NHS England.

Patients are now benefiting from significantly improved extended access to GP appointments. Appointments are now available from 6:30pm – 8:00pm on Monday to Friday and access is also provided on Saturdays, Sundays and Bank Holidays at four hubs in different geographical locations in Wolverhampton. There has also been an increase over the year in our Rapid Response team of nurse practitioners who can support patients in care homes or in their own homes, which means that they can receive swift treatment without going into hospital.

Our Primary Care Networks continue to mature and in 2018 we commissioned a QOF+ (Quality and Outcomes Framework) scheme to encourage health prevention in our GP Practices. The scheme is designed to identify patients at risk of developing diabetes and those who consume too much alcohol or are overweight who could then be included on a GP Practice register and appropriate advice and interventions given

Over the year we have progressed our Integrated Care Alliance (ICA), which is the work that we are doing with partners across the city to keep people healthier for longer right from birth.

And to ensure that they are able to access the services that they need as close to their homes as possible, relieving pressure on our acute hospitals where possible. Listening to and delivering on what the people of Wolverhampton have been telling us they want from their local health services is paramount. Our collective aim is to create a city where people can thrive and make healthy choices, no matter what their background.

By bringing key partners together, we can create care wrapped around the individual and their needs, keeping them independent at home or in the community wherever possible. Four key workstreams are currently being progressed; End of Life; Frailty; Children and Young People and Mental Health. Working with Primary Care to develop GP Networks and developing innovative out of hospital solutions are pivotal to the success of the ICA. We have been trialing our pilot GP Home Visiting Service, which aims to free up more GP time in surgeries for more preventative work with patients.

Our aim is to be innovators in healthcare and we were the first CCG to implement free NHS patient Wi-Fi last year and also one of the first areas to implement GP online triage and GP online video consultation. We are currently working on exciting initiatives such as online consultations for patients that are unable to physically attend appointments. Pilots are currently being undertaken to support the roll out and development of online services (triage and consultation) and these services are in addition to a wider plan that also includes raising awareness of prescription ordering, online booking of appointments and improved patient access. Alongside this, the introduction of a two way texting system for practices and patients to use has led to reduced 'Do not attend' rates as text reminders are now sent to patients.

We recognise that the emotional wellbeing of children is just as important as their physical health. So, it was very satisfying to launch an innovative new service to help improve the emotional mental health and wellbeing of thousands of children and young people in Wolverhampton. The BEAM Wolverhampton service is commissioned by our CCG in partnership the City of Wolverhampton Council and HeadStart Wolverhampton and will support over 2,000 children and young people every year.

Young people aged 11 – 18 can now also benefit from a new online counselling service which we launched during the year. The service, which is provided by Kooth, is a free, safe, confidential and non-stigmatised way for young people to receive counselling, advice and support on-line.

We are working to improve health services across all life stages and one of our key priorities is that every person nearing the end of their life should receive attentive, high quality, compassionate care. Working with our partners we launched a newly developed Integrated Advance Care Plan in September 2018. This new, more personalised, care plan is integral to the delivery of excellent End of Life care across the City of Wolverhampton.

We continue to work collaboratively with partners in the Black Country and West Birmingham Sustainability and Transformation Partnership (STP), which aims to deliver sustainable, integrated health and care services that improve the health, wellbeing and prosperity of our residents. Key achievements over the year include a new specialist perinatal mental health service, introducing new workforce schemes that encourage GPs to stay in the primary care

workforce and a cash injection of £79.4 million to modernise and transform NHS services and healthcare facilities across the Black Country and West Birmingham.

It was clear from our NHS 70 celebrations that local people in Wolverhampton share our passion for the NHS. On Friday 6 July, I was able to meet with local people, health and social care guests as we celebrated this special birthday at a tea party in the café at Sainsbury's St Marks. Members of the public shared their experiences of the NHS and it was so good to hear people's positive stories of how the NHS has looked after them over the years.

NHS70 highlighted that the British public are immensely proud of the NHS and the Long Term Plan, launched in January 2019, will ensure the NHS is fit for future generations. In Wolverhampton we have already been pioneering some of the initiatives which will use the latest technology, such as digital GP consultations for all those who want them, coupled with early detection and a renewed focus on prevention to stop an estimated 85,000 premature deaths each year. We have continued to be involved with new technologies and were selected as one of the beta sites for the NHS App.

Looking ahead, working with primary, community and mental health services is absolutely key to improving the patient experience. We will be working on our local plan for 2019/20 which will outline how we work with our partners, both in our local place and more widely across the STP area. This strategy will set out how we intend to take the ambitions that the NHS Long Term Plan details, and work together to turn them into local action to improve services and the health and wellbeing of our population.

We will ensure that whatever we do, local people remain at the heart of our decision making. As a CCG we will work tirelessly to maintain our outstanding levels of performance for the people of Wolverhampton so that they continue to benefit from innovative services and high quality healthcare when and where they need them.

**Dr Helen Hibbs**

**Accountable Officer**

# PERFORMANCE REPORT

## About us

Wolverhampton Clinical Commissioning Group (WCCG) was set up under the Health and Social Care Act 2012. We were fully authorised by NHS England in October 2013 and have a budget of £424,036 million to buy healthcare services for people living in Wolverhampton. We are a clinically led organisation, comprising 40 GP practices, and we provide healthcare services for the circa 277,000 patients who are registered with a GP in Wolverhampton.

## Our local population

Wolverhampton is located in the Black Country in the West Midlands. It currently has a population of circa 260,000 city council residents, which is estimated to grow to 286,394 by 2041. Wolverhampton is a diverse city and 35.5 per cent of our population belongs to black minority ethnic (BME) communities compared to 15 per cent for England.

Wolverhampton is one of the most densely populated local authority areas in England with a population density of 37 people per hectare. Wolverhampton is ranked 17 out of 326 districts for deprivation, putting it in the 20% most deprived districts nationally. Unemployment in Wolverhampton is higher than the national average. Figures from October 2017 – September 2018 show 6.7% of people in Wolverhampton were unemployed compared to 4.2% nationally.

## Social and community issues

Premature mortality (under 75 years) is improving in Wolverhampton but there are still significant inequalities between men and women, and between affluent and deprived areas. Healthy life expectancy data shows that in Wolverhampton, men and women live 7 and 4.6 years respectively in poorer health than the England average. Men living in deprived areas of Wolverhampton can expect to live 11.3 years in poorer health than those in affluent areas and for women this is 9.5 years. It is these years lived in poor health that leads to higher demand on our health and social care services in Wolverhampton.

Infant mortality rates in Wolverhampton are the seventh highest of our 16 nearest neighbourhoods and at 5.6 per 1,000 births are within the bottom quartile of local authorities and remain significantly high compared to the England rate of 3.9 per 1,000 births.

Today, approximately 18.7% of the population of Wolverhampton were born outside the UK, including a growing population of migrant workers from eastern Europe. Over the last 20 years, significant numbers of asylum-seekers and refugees have settled in Wolverhampton, and just under 800 asylum-seekers were housed and supported by the Home Office in March 2017. Migration places individuals in situations which may affect their physical and mental wellbeing and this has an impact on our health and social care services.

There has been a rapid improvement regarding teenage pregnancies in Wolverhampton. These are down from 56.8 per 1,000 in 2010 to 28 per 1,000 now. However, this is still higher than the England average (17.7) and West Midlands (21.1).

## **Our structure and commissioning activities**

We are responsible for commissioning (or buying and monitoring) healthcare services as described in the 2006 National Health Service Act and as amended by the 2012 Health and Social Care Act. These health services include:

- Health services that meet the reasonable needs of all patients registered with our member practices, as well as people living in Wolverhampton who are not registered with any GP practice
- Emergency care
- Paying for prescriptions issued by our member practices.

To meet those needs, we commission a wide range of services including:

- GP Primary Care services
- Acute or hospital services
- Community services
- Prescribing
- Mental health services
- Ambulance services
- Continuing care
- Nursing home care.

We buy most of our acute and community services from The Royal Wolverhampton NHS Trust (RWT), but we also have contracts with other acute trusts outside Wolverhampton. We buy most of our mental health services from the Black Country Partnership NHS Foundation Trust (BCPFT). We also sometimes buy services from other healthcare providers outside the city or from non-NHS organisations, depending on the nature of patient's health needs and requirements.

Since we became responsible for the commissioning of GP Primary Care services in April 2017, we have been working very closely with GPs to:

- improve collaborative working between GP practices
- improve access including evening and weekend 'Hub based' services
- extending and enlarging the range of services which can be provided by local GPs
- Enhancing the working relationships between GPs, acute and community services to improve seamless and consistent patient care.

## **Black Country and West Birmingham Sustainability and Transformation Partnership**

We continue to work collaboratively with partners in the Black Country and West Birmingham Sustainability and Transformation Partnership (STP).

The collective aim of the Partnership is to deliver sustainable, integrated health and care services that improve the health, wellbeing and prosperity of our residents.

As a member of the STP, we contribute to the development of system-wide improvement plans that deliver financially and clinically sustainable services across the Black Country and West Birmingham. Through this work, the STP have identified three distinct but interconnected 'accountabilities' that outline what we are trying to achieve together. They are:

- Working at scale across the Black Country with the Combined Authority, our local councils and other stakeholders to address the wider, economic and social determinants of health that can make a positive difference to people's wellbeing.
- Collaborating on key areas such as mental health and cancer services that will enable us to deliver higher quality healthcare to our communities and better outcomes for patients.
- Integrating hospital, community, primary and social care services on a place-by-place basis.

During 2018/19, the STP strengthened its governance arrangements by appointing a Senior Responsible Officer, Independent Chair, Portfolio Director and a Project Management Office (PMO) team.

Achievements over the year include:

- A maternity 'You Said, We Did' event to demonstrate how the views of over 200 women and families were used to develop **personalised, family-friendly maternity services** across the Black Country and West Birmingham.
- A new **specialist perinatal mental health service**, secured with £1.2m of investment. The service provides timely support and treatment for pregnant women and new mums.
- Bringing together more than 60 mental health professionals to improve the **joint commissioning and delivery of a range of mental health services** across the Black Country.
- Developing a clinical strategy with local clinicians and agreeing 12 health priorities for the next five years. The clinical strategy will support health and care organisations to raise the quality of services provided to patients and commit to a culture of continuous improvement and co-production - **ensuring better health, better care and better value of services**.
- Introducing new workforce schemes that **encourage GPs to stay in the primary care workforce**. Up to £400,000 was made available to the STP, to promote new ways of working and offer additional support to local GPs. As part of this work, the Black Country and West Birmingham was named a **GP Retention Intensive Support Site** and to date have received over 200 expressions of interest from local GPs to participate in the workforce schemes.
- A cash injection of £79.4 million to **modernise and transform NHS services and healthcare facilities** across the Black Country and West Birmingham. The modernisation projects include £36.2m on a new emergency department and acute medical unit at Walsall Manor Hospital, £20.3m on a redesign of Russells Hall Hospital's emergency department, £15.4m on Information & Technology (IT) and estate upgrades at Birmingham City Hospital and £7.5m on a new purpose built facility for people with learning disabilities.

As the year has progressed, so too has our journey towards an Integrated Care System (ICS), both in our neighbourhoods and across the Black Country and West Birmingham. Our integrated health and care relationships will continue to grow and strengthen during 2019/20 as we take collective responsibility for delivering improvements set out in the NHS Long Term Plan and when we involve and listen to the views of our local communities as we develop our response to the Long Term Plan.

## **Sustainable development**

The CCG's sustainability responsibilities were met in 2018/19 and will continue to develop throughout 2019/20. The Governance Statement highlights the work of our accommodation partner and outlines our plans to work effectively as a CCG whilst working robustly with our

providers to ensure the services we commission are delivered in a sustainable way. We also continually examine our internal processes to ensure we meet our obligations through initiatives such as the use of technology to further embed paperless working, and the introduction of a Sustainable Development Management Plan in line with national best practice.

## **Factors likely to affect future development and performance**

### **Risks and uncertainties**

The CCG works continuously to ensure that it clearly understands and takes action to address the risks that it faces. Our approach to this is set out in our risk management strategy, which sets out how risks are identified, managed and monitored throughout the organisation. Our multi-layered approach to managing risk means that risks are continually assessed to understand their potential impact on individual projects, programmes of work and strategic objectives. Risks are escalated throughout the organisation as appropriate with the Governing Body assessing the potential impact of strategic risks to organisational objectives. This informs the CCG's Governing Body Assurance Framework (GBAF) which assesses the level of risk of us achieving our three strategic objectives:-

- **Improving the quality and safety of the services we commission**
- **Reducing health inequalities in Wolverhampton**
- **System effectiveness delivered within our financial envelope.**

The GBAF is regularly reviewed by both the Audit and Governance Committee and the Governing Body and recognises the following areas of risk:-

#### **Improving the quality and safety of the services we commission**

We recognise that specific concerns about quality may impact on achieving this objective. In particular we have recognised and are actively managing risks associated with cancer services, maternity systems and hospital mortality rates across the system. The CCG's robust quality management approach has helped to identify these areas of risk and develop approaches to ensure that actions plans are developed in mitigation that enable quality concerns to be addressed at the earliest opportunity. This helps to mitigate the overall risk that work to address these issues may impact on the overall resources available to improve services for patients across the system.

#### **Reducing health inequalities in Wolverhampton**

In commissioning services for our patients, we are committed to reducing inequalities experienced across the City. In some areas this means responding to significant challenges which can only be achieved through significant changes in the way we work. This includes new ways of working across Primary Care through practices working together to deliver services at scale, continued integration between health and social care services and working with provider organisations across the system to deliver better outcomes for patients.

Working to deliver this kind of change brings its own risks, including capacity of partners to support change management programmes alongside their existing work. There are also a number of specific risks associated with the changing approach to Primary Care – particularly to how we work to continue to ensure there is a sustainable and suitable Primary Care workforce for future years. We are working to address these challenges through the continuous development of our Primary Care Strategy, and working collaboratively on change programmes our partners across both Wolverhampton and the wider Black Country.

## **System effectiveness delivered within our financial envelope**

In common with all other NHS and public sector organisations we face challenges to ensure we continue to achieve our aims and objectives within the resources available to us. In meeting these challenges, we are responding to the national strategic direction to support closer working across the health and care system through the STP. This means working with partner NHS organisations and local authorities across the Black Country to deliver meaningful change for the public and patients. There are risks associated with aligning different organisational aims and work programmes in a common direction, including ensuring that our local work to deliver systemic change in Wolverhampton supports the overall direction of travel. This also creates challenges for our staff, who are being asked to work differently in an environment with a degree of uncertainty as a result of on-going change and for our patients and public who need assurance that the changes being developed will deliver the improvements in their health and care that are required. We continue to mitigate these risks through open channels of communications about our future plans with our patients and our staff so that, as plans are developed opportunities to be involved and informed are clear.

Our approach to all of these areas of risk is to recognise that, whilst we will work to reduce both how likely risks are to occur and their level of impact, they cannot always be avoided and we need to understand how to manage them effectively. As a CCG, we have a complex range of responsibilities and we ensure that managing risk and uncertainty is part of everyone's role; helping to ensure that the impact of risks to achieving our objectives are minimised.

## **Financial review of the year**

Wolverhampton CCG is required to meet both national and local financial targets, the national targets being defined in the NHS Act 2006 (as amended). The CCG has achieved all of its statutory duties. The performance against targets is detailed below.

<b>2018/19 Performance</b>	<b>Target</b>	<b>Actual</b>
<b>Statutory duties:</b>		
Expenditure not to exceed income	£9.986m surplus	£10.028m surplus
Capital resource use does not exceed the amount specified in Directions	Nil	Nil
Revenue resource use does not exceed the amount specified in Directions	£414.050m	£414.008m
Revenue administration resource use does not exceed the amount specified in Directions	£5.516m	£5.442m
<b>Non-statutory duties:</b>		
Better Payment Practice Code: NHS	95%	99%
Better Payment Practice Code: Non-NHS	95%	98%
Cash drawdown target	Achieve	Achieved
QIPP (Quality, Innovation, Productivity and Prevention)	£13.948m	£13.948m

The CCG commenced the financial year with a target surplus of £9.986m and ended the financial year with a surplus of £10.028 million, £42k in excess of plan. The responsibility for

the commissioning of Delegated Primary Care (General Medical Services) was transferred to the CCG from NHSE on 1 April 2017.

WCCG has managed its responsibilities within a financial envelope of £424.036m which encompasses both the commissioning of healthcare services, Delegated Primary Care and Management 'running' Costs. The healthcare allocation (Programme Costs) is determined by NHSE using a complex formula designed to take into account the health needs of our population. It has been spent on healthcare services such as those delivered by RWT, BCPFT and a wide range of voluntary/third sector organisations.

The Running Cost allocation pays for the cost of employing staff, running the organisation and all the support systems the CCG requires to commission and monitor services. The CCG spent £5.442m, approximately £19.27 per head of population on Running Costs a small reduction on last year (£19.37). The CCG has developed an organisational structure which best supports the delivery of the CCG's 2-5 year Operating Plan. It ensures that decisions are made with effective clinical input through individual clinicians and membership practices, and sufficient resource is allocated to monitor the impact of our decisions.

During the year the CCG has received additional allocations totaling £11.4m. The table below details the move between opening and closing allocations.

	<b>Opening £'m</b>	<b>Closing £'m</b>	<b>Increase £'m</b>
Programme allocation	360.585	371.919	11.334
Delegated Primary Care	36.552	36.571	0.019
Running Cost allocation	5.515	5.5602	0.045
Surplus	9.986	9.986	0
<b>Total</b>	<b>412.638</b>	<b>424.036</b>	<b>11.398</b>

The table below summarises the CCG's performance against its financial allocation as at the end of March 2019 and reflects the financial position reported in the CCG's annual accounts.

	<b>Annual Plan £m</b>	<b>Actual £m</b>	<b>Variance under/(over) £m</b>	<b>Variance % %</b>
Healthcare Allocations	408.49	408.49		
Running Cost Allocation	5.56	5.56		
Brought Forward Allocation	9.99	9.99		
<b>Total Allocations</b>	<b>424.04</b>	<b>424.04</b>		
<b>Expenditure</b>				
Acute Services	202.32	204.10	-1.78	-0.9%
Mental Health Services	39.91	40.68	-0.77	-1.9%
Community Services	40.88	40.57	0.31	0.8%
Continuing Care/Funded Nursing Care	15.06	14.88	0.18	1.2%
Prescribing	53.94	53.36	0.58	1.1%
Delegated Primary Care	36.57	35.80	0.77	2.1%
Other Programme Costs	18.58	19.18	-0.60	-3.2%
Reserves	1.24	0.00	1.24	100.0%
Running Costs	5.56	5.44	0.12	2.2%
<b>Total Expenditure</b>	<b>414.05</b>	<b>414.01</b>	<b>0.04</b>	<b>0.0%</b>
Revised Target (NHSE)	9.99	9.99	0.00	
<b>Underspend in excess of Revised Target</b>	<b>0.00</b>	<b>0.04</b>	<b>0.04</b>	

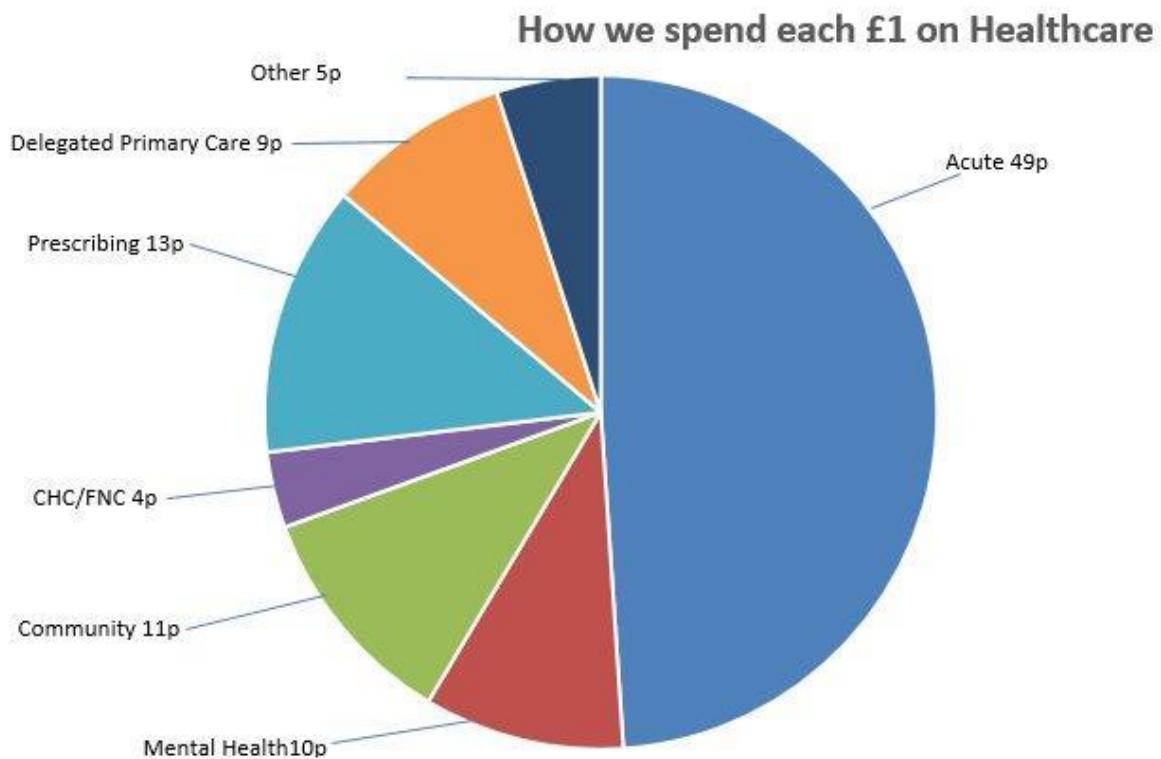
During 2018/19 the CCG has developed and operated an Aligned Incentives Contract, AIC, with its main Acute and Community provider, RWT. This development represents a significant step towards working as a healthcare system across Wolverhampton, recognising risks associated with transformation and developing a risk share agreement with the intention to create a financially stable and sustainable health economy. In 2018-19 the over spend on Acute services has almost halved from last year (£3.34m or 1.7%) supported by the planned increased investment in community and primary care services.

In achieving this position there were a number of significant variances from plan:

- Acute contracts were £1.78m, (0.9%) over plan which was mainly attributable to increased emergency admissions (predominantly in General Medicine and Frailty services). However, levels of elective activity have been much lower than anticipated
- Mental Health Service spend exceeded plan by £770k, and this reflects the complexity of care required by patients and the need for placements in out of area facilities
- Community Services underspent mainly due to the negotiation of an risk/gain cap on Better Care Fund and AQP underperforming
- Delegated Primary Care underspent mainly as a result of slippage in planned schemes and the reduced levels of spend on other claims such as locums, maternity and sickness.

## Spend per head of population

In 2018-19 the CCG spent an average of £1,468 per person on providing healthcare services to people registered with a WCCG practice. This is how we spent each £1 in 2018/19:



## Our Accounts

The CCG's accounts have been prepared under a direction issued by NHSE under the National Health Service Act 2006 (as amended). The CCG's Statement of Financial Position is set out on page 78.

The main assets that the CCG holds as at 31 March 2019 are short term receivables (amounts owed to the CCG by third parties) and the main liabilities are short term payables (amounts owed to other parties by the CCG). The CCG does not hold any significant operational assets.

## Going Concern

The CCG has met all financial targets for the year, including containing our administrative running costs within the allowance of £5.56m million. Further, it is expected that CCG - commissioned services will continue to be provided in Wolverhampton beyond the date for which our financial statements relate. In preparing our annual financial statements, we have considered the CCG to be a "going concern".

## How we're doing

### Our strategy

Our vision for the future is to commission the right healthcare services for our population, in the right place, at the right time, within the context of limited resources.

In order to achieve this, we have four priorities for the coming year:

- continue to commission high quality, safe healthcare services within our budget
- focus on prevention and early treatment
- ensure our services are cost effective and sustainable
- increase the capacity to deliver services in Primary Care and community settings in a strong and collaborative way with social care partners.

We will do this with the help of the people of Wolverhampton. It's important to us that people who use our services are fully involved in helping us design them going forward. It is only by understanding patients' needs that we will get things right for them.

Our five-year strategy for improving healthcare in Wolverhampton focuses on a number of themes:

- we want to reduce hospital admissions and provide more care closer to home through community-based services, improving co-ordination and access
- we will focus more on preventing illnesses, working with public health to look at lifestyle factors that increase the risk, including obesity. We will also continue to improve uptake of the NHS Health Check programme
- we want to give patients better access to GPs, but also reduce pressure on practices through new ways of people accessing GPs – using new technologies for example
- we want to improve mental health services, provide better care and more choice to people with long-term mental health problems who are living in, and need greater support in the community
- we will improve access to mental health treatment, crisis and home care so that children and young people are treated in a timely manner by local services
- we will continue to expand our service for children who need counselling or therapeutic support
- we will work to improve dementia diagnosis, treatment and care, and implement national standards for mental health service waiting times
- we are committed to providing good quality children's services and are working with public health to reduce Wolverhampton's high infant mortality rate which is currently one of the highest in England
- we want to improve co-ordination of services and care for children with special educational needs and disabilities to ensure appointments occur in a convenient place and time and reduce the amount of time spent out of a learning environment
- we want better quality of care. We will continue to monitor the safety of services, work to reduce healthcare associated infections and improve services based on patient feedback
- we want to increase the uptake of personal health budgets
- we will continue to improve Information Technology (IT) in our GP practices to improve access to and sharing of information
- we want better seamless health and social care. We will continue to work with the City of Wolverhampton Council (CWC) to provide joined-up health and social care that delivers high-quality services through best use of our joint investment. We will transform services in a way that is sensitive to local needs and sustainable for the long term.

## **Assurance performance**

The CCG has continued to effectively manage and commission local healthcare services and this work has been recognised by NHS England who awarded WCCG an 'Outstanding Performance' rating for their annual assurance assessment for 2018/19. This achievement maintains WCCG's position in the top 10% of all CCG's nationally and one of only three CCGs to maintain this standard in successive years.

## **Primary care**

### **Primary care strategy**

The CCG's vision for primary care is to achieve high quality out of hospital care which is accessible to everyone. This will, in turn, promote the health and wellbeing of our local community. We want to ensure that the right treatment is available in the right place at the right time and to improve the quality of life of those living with long term conditions and reduce health inequalities.

As a membership organisation we are committed to working with our GPs and our strategy has been co-designed with our member practices. Our Group Leads continue to work together as groups of practices mature.

As part of the Primary Care Strategy we established task and finish groups in 2016. There are six groups that remain focussed on delivering the strategy. Significant progress has been made in response to the General Practice Forward View (GPFV). This transformation work continues and largely focuses on the general practice workforce, care redesign and workload. Importantly, all available allocations have been utilised to escalate this programme of work.

As a fully delegated CCG we continue to work in close liaison with our neighbouring CCGs across the STP footprint, along with other stakeholders such as NHS England and a range of commissioned providers including Relate Counselling Service and The Sound Doctor.

### **Services at scale**

In Wolverhampton our GP Practices have been working together for some years. Primarily improving access to general practice has been their priority, but in 2018 practice groups have built on those firm foundations to provide additional services to patients by hubs opening during the evening and weekends. Primary Care in Wolverhampton has been a seven day service since September 2018, with hubs offering improved access and appointments with a range of healthcare professionals including pharmacists and nurses.

GP practice groups have actively responded to new guidance issued by NHS England that will make them more focused and able to do more targeted work with their communities to provide care in different ways.

Great importance is being placed upon patients being able to access the right care, in the right place at the right time through being navigated to the most appropriate professional, not always a GP. Practice teams have expanded to include pharmacists, physician's associates, care navigators and social prescribers.

## **Assurance**

The Primary Care Commissioning Committee are appraised of progress, a reporting pack is shared publicly at quarterly intervals to confirm what activities have taken place and those activities planned for the coming three months. Improving the quality of care patients receive in the city is a priority, particularly in general practice. Over the coming year practices will work closer together to provide more care closer to home.

## **Performance overview**

NHS England has a statutory duty to conduct an annual performance assessment of every CCG. The annual assessment will be a judgement, reached by taking into account the CCG's performance in defined indicator areas over the full year and balanced against the financial management and qualitative assessment of the leadership of the CCG. The CCG Improvement Assessment Framework contains the metrics that will inform NHS England's assessment of CCGs for 2018/19.

Performance is assessed against a selection of Quality Indicators covering six vital clinical areas (cancer, dementia, maternity, mental health, learning disabilities and diabetes). The CCG can be awarded outstanding, good, requires improvement or inadequate.

End of year ratings are expected to be published by NHS England in the summer of 2019 and will be published on My NHS found at [www.nhs.uk](http://www.nhs.uk).

NHSE rated Wolverhampton CCG as Outstanding in 2017/18 for the third year in a row and one of only 16 CCGs achieving the top rating across England.

## **Performance analysis**

WCCG's overall approach is based on:

- Collaborative matrix working approach across the CCG ensures hard and soft intelligence from performance, contracting, finance, quality and providers is triangulated to manage performance proactively
- Continual **Monitoring** of performance through established mechanisms
- Using in-house analytical expertise to ensure there is a clear understanding of the issues
- Using this insight to support **Action** through contractual means where necessary to address issues and provide **Assurance**, both through internal governance processes (including Finance & Performance and Quality & Safety Committees) and externally as appropriate
- Supported by clear strategies and policies around performance management and data quality
- Building positive working relationships with providers to address issues at an early stage

In areas where we have faced challenges to meet performance targets, we are aware of the underlying reasons and are taking action to address these. We've also put a great deal of time, energy and effort, plus additional financial investment, into working with the Acute Trust to address specific areas of concern such as Referral to Treatment Times and Cancer Waiting Times.

The Five Year Forward View and the Planning Guidance set out national ambitions for transformation in six vital clinical priorities:

**1. Cancer – 2017/18 CCG Rating: Requires Improvement,  
2018/19 CCG Rating: Awaiting publication**

WCCG and RWT have worked in partnership with NHS England, NHS Improvement and the West Midlands Cancer Alliance to implement actions to improve the cancer waits performance. Whole Health Economy action plan has been refreshed with support from the NHS Intensive Support team (IST) through the cancer network:

- Implementation of pathway redesign and service improvements to improve the waiting times and % of cancers diagnosed at stages 1 and 2 in line with the National Cancer Strategy
- Complete redesign of the Urology pathways to implement 28 day faster diagnosis. Wolverhampton is one the first Trusts to do this and is now being used as an example of best practice
- Working with clinical colleagues and patients and carers across the cancer pathways to improve patient and carer experience

**2. Mental Health – 2017/18 CCG Rating: Good  
2018/19 CCG Rating: Awaiting publication**

WCCG has continued to work with The Black Country Partnership Foundation Trust to ensure high quality of data flows to the Mental Health Services Data Set. The gap in provision identified in 2017/18 resulted in the commissioning of an emotional mental health and wellbeing service which has increased access rates in 2018/19 for Wolverhampton CCG's Children and Young people.

The CCG has worked extensively to improve access recovery and reliable improvement rates along with Improving Access to Psychological Therapies (IAPT) waiting times and we are pleased that we have delivered to target across the majority of the year.

Early Intervention in Psychosis access rates are very sensitive due to the very low numbers, but the national standard has been achieved in nine out of twelve months this year.

We work to minimise our Out of Area Placements (but this cannot be zero as we have no female Psychiatric Intensive Care Unit in the Black Country) and we are working on this proactively.

**3. Dementia – 2017/18 CCG Rating: Requires Improvement  
2018/19 CCG Rating: Awaiting publication**

WCCG continues to perform well in relation to diagnosis rates for people with dementia with 2018/19 performance achieving 72.8% against a target of 66.7%. The CCG was best in the Black Country and better than the National performance of 68.7%.

Following poor performance in 2017/18 the CCG has worked closely with Mental Health Providers, Local Authority and Primary Care Teams to improve Dementia post diagnostic support in 2018/19 and is currently has over 85% of those patients diagnosed with dementia care plan has been reviewed in a face-to-face review in the preceding 12 months.

#### **4. Diabetes – 2017/18 CCG Rating: Requires Improvement 2018/19 CCG Rating: Awaiting publication**

WCCG was successful in their application as part of the National Diabetes Treatment and Care Programme from 2017/18 and from April to December 2018 146 people with diabetes have attended a structured education course which aims to help people with diabetes to improve their knowledge, skills and confidence. Q4 data was not available at the time of publication.

The CCG rolled out a new comprehensive EMIS data entry template to support the Quality Plus Outcomes Framework (QOF+) in Primary Care in December and January.

Stretch targets have been introduced to a number of indicators together with an indicator for the eight care processes which in return should support improvement in the achievement of treatment targets. Currently 34.6% of diabetes patients have achieved all three of the NICE-recommended treatment targets. The CCG intends to keep diabetes within the QOF+ framework for 2019/20 which will support continued improvement in performance against this target.

#### **5. Learning Disabilities – 2017/18 CCG Rating: Requires Improvement 2018/19 CCG Rating: Awaiting publication**

WCCG has worked to deliver timely care and treatment reviews and embedded new services to support alternatives to admission and to facilitate timely discharges. We have reduced the number of adult admissions, and the length of stay, although we still have high number of inpatients who are on forensic pathways (i.e. offenders). New services, including a Black Country specialist forensic health service, a Black Country Intensive Support Service and a new framework for forensic social care providers have all been embedded during 2018/19.

The CCG is supporting member practices via an Enhanced Service to increase the offer and uptake of the Learning Disability Health Checks together with providing patients an appropriate care plan. The Enhanced Service also focusses on improving the quality of data collected in primary care. Additional actions undertaken by the CCG are an ongoing local improvement plan concentrating on improving GP engagement, refreshing GP training and patient and public awareness. We have also undertaken quality audits of the resulting Health Action Plans and provided feedback to the GPs.

#### **6. Maternity – 2017/18 CCG Rating: Requires Improvement 2018/19 CCG Rating: Awaiting publication**

**Patient choice** - All women at the time of booking are offered options for their preferred choice of birthplace and Maternity Service. RWT offers three types of birthplace options:

- Birth at home
- Midwifery led unit
- Obstetrics led unit

In addition the past 12 months has recognized the Continuity of Carer (CoC) national trajectory, this requires providing a pregnant woman with a primary or named midwife who will give the majority of her antenatal intrapartum and postnatal care. It is expected that RWT will achieve the trajectory of 20% by April 2019.

**Smoking at the time of delivery** - Carbon Monoxide (CO) testing is offered to all pregnant women at antenatal booking appointments and active signposting, as appropriate, to a stop

smoking information website. WCCG has supported the recruitment of a Smoking Cessation Nurse to provide target support to the most vulnerable women in Wolverhampton.

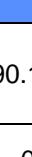
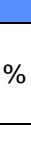
**Still Births** - In support of the national ambition to reduce the rate of stillbirths in England by 20% by 2020 and 50% by 2030, RWT have implemented all four elements of the Saving Babies Lives Care Bundle. This work is being led through the Black Country and West Birmingham Local Maternity System (BCWBLMS).

1. Reducing smoking in pregnancy - All women have CO monitoring performed at each antenatal contact
2. Risk assessment and surveillance for fetal growth restriction - Midwives receive growth training to ensure that their skills and capability are maintained
3. Raising awareness of reduced fetal movement - Fetal movement information has been developed and issued to all women
4. Effective fetal monitoring during labour - RWT have introduced multi-disciplinary cardiotocograph (CTG) update training for all staff on a 6 monthly cycle.

**Women's Experience of Maternity Services** - The results of the 2018 CQC Maternity Survey have now been published by the CQC and RWT is in line with most other trusts in England. Areas for improvement and progress have been reviewed with the Head of Midwifery, an action plan has been developed which will be monitored via the Clinical Quality Review Meeting, Quality & Safety Subgroup.

The Black Country and West Birmingham Local Maternity System have led work on a shared care maternity record across the Black Country; this is expected to enhance maternity experience for all women. The use of single portal AP has also been well received by pregnant women, with positive feedback generated. The development of the Maternity Voices Partnership in Wolverhampton has assisted the service to develop women centred care in a more co-productive way.

### Performance against the key national NHS Constitution targets for 2018/19

		National Target	Performance	PERFORMANCE											
				A	M	J	J	A	S	O	N	D	J	F	M
<b>Referral to Treatment waiting times for non-urgent consultant-led treatment</b>															
EB3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from referral.	92%	90.1%												
EBS4	Zero tolerance RTT waits over 52 weeks for incomplete pathways.	0	0												
<b>Diagnostics</b>															
EB4	Percentage of Service Users waiting 6 weeks or more from referral for a diagnostic test.	1%	0.7%												
<b>Cancelled Elective Operations (RWT)</b>															
EBS2	All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice. (RWT position).	0	0												
EBS6	No urgent operation should be cancelled for a second time. (RWT position).	0	0												
<b>A&amp;E Waits</b>															

		National Target	Performance	PERFORMANCE											
				A	M	J	J	A	S	O	N	D	J	F	M
EB5	Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department (RWT* position).	95%	90.8%	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Red	Red	Red	Yellow
EBS5	Trolley waits in A&E not longer than 12 hours (RWT* position).	0	7	Green	Red	Green	Red	Green	Red	Green	Red	Green	Red	Green	Red
<b>Cancer Waits - two week waits</b>															
EB6	Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment.	93%	73.2%	Red	Red	Red	Yellow	Red							
EB7	Percentage of Service Users referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment.	93%	6.7%	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
<b>Cancer Waits - one month (31 days) waits</b>															
EB8	Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers.	96%	89.2%	Green	Yellow	Yellow	Yellow	Red	Yellow	Red	Red	Yellow	Red	Yellow	Red
EB9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery.	94%	66.7%	Green	Yellow	Red	Green	Red	Yellow	Red	Red	Red	Red	Red	Red
EB10	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen.	98%	100%	Green	Green	Green	Yellow	Green	Green	Green	Green	Green	Yellow	Green	Green
EB11	Percentage of service Users waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy.	94%	92.3%	Green	Yellow	Yellow	Red	Red	Red	Green	Red	Red	Red	Yellow	Red
<b>Cancer Waits - two month (62 days) waits</b>															
EB12	Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer.	85%	76.0%	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
EB13	Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from a NHS Cancer Screening Service.	90%	100%	Yellow	Yellow	Red	Green	Red	Green	Red	Red	Red	Yellow	Red	Green
EB12	Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	No National Target	78.7%	Grey	Grey	Grey	Grey	Grey	Grey	Grey	Grey	Grey	Grey	Grey	Grey
<b>Health Care Acquired Infections</b>															
EAS4	Zero tolerance Meticillin Resistant <i>Staphylococcus Aureus</i> .	0	2	Green	Green	Green	Red	Green							
EAS5	Minimise rates of Clostridium difficile.	70	44	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
<b>Mental Health</b>															
EBS3	Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care.	95%	98.1%	Yellow	Green										
EH1	IAPT - Percentage of people engaged in the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral.	75%	81.4% (Feb data)	Green	Green	Green	Green	Green	Red	Red	Red	Green	Green	Green	**

		National Target	Performance	PERFORMANCE											
				A	M	J	J	A	S	O	N	D	J	F	M
EH2	IAPT - Percentage of people referred to the Improved Access to Psychological Therapies programme will be treated within 18 weeks of referral.	95%	100% (Feb data)	Green	Green	Green	Green	Green	Green	Green	Red	Green	Green	Green	Green
EA3	IAPT - People who have entered treatment as a proportion of people with anxiety or depression (local prevalence).	19%	16.7% (Feb data)	Yellow	Yellow	Yellow	Yellow	Yellow	Green	Green	Yellow	Yellow	Yellow	Yellow	Yellow
EAS2	IAPT - Percentage of people who are moving to recovery of those who have completed treatment in the reporting period.	50%	60% (Feb data)	Red	Red	Red	Green	Green	Green	Green	Green	Green	Green	Green	Green
EH4	Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis who commenced a NICE-concordant package of care within two weeks of referral.	53%	100%	Red	Green	Green	Green	Green	Green	Red	Green	Green	Red	Red	Green

*Current performance is as published validated national data for Wolverhampton CCG unless indicated otherwise, i.e. only available at Trust level.*

\*RWT - The Royal Wolverhampton NHS Trust

## Summary of key performance targets

### Referral to Treatment (RTT) within 18 weeks

This indicator measures waiting times from referral to the start of first definitive treatment, in weeks at treatment specialty level. The length of the RTT period is reported for patients whose RTT clock stopped during the month, and those who are waiting to start treatment at the end of the month.

As at March 2019 of the Wolverhampton CCG patients waiting to start elective treatment at any provider in England; half were waiting less than 6.5 weeks and 92% of patients started treatment within 19.2 weeks against a target of 18 weeks. Nationally 84.3% patients started treatment within 18 weeks and Regional performance was 87.3%.

Those patients referred to RWT (from any CCG) had an average waiting time of 7 weeks and 92% of patients started treatment within 20 weeks.

### Referral to treatment (RTT) waits over 52 weeks

There have been no patients waiting over 52 weeks to start treatment at the CCG's main acute provider RWT.

There have been a small number of WCCG patients experiencing waits of 52+ weeks from referral to treatment at other Providers; primarily this has been for Trauma and Orthopedic patients awaiting treatment at the Royal Orthopedic Hospital, predominantly spinal surgery. We continue to work to eradicate any waits over 52 weeks.

### Diagnostic tests

Performance is primarily affected by issues at RWT who have been affected by increased referrals in Endoscopy, Gastroscopy, Colonoscopy and Flexi Sigmoidoscopy. This is a consequence of the continued increase in cancer referrals. Performance has returned to standard for both the CCG and RWT from February 2019.

## **A&E Four Hour Waits**

The national standard requires that 95% of patients should be transferred, admitted or discharged within four hours of arrival at an A&E department. The pressures and challenges to meeting the national target in 2018/19 in Wolverhampton are no different to that nationally.

Performance for 2018/19 at RWT (Type 1 and Type 3 combined) was 90.8% in March 2019 compared to National performance 86.6% and 85.7% across The Black Country. Although RWT fell short of the national target in March, only 19 acute trusts out of 136 in England achieved the national standard with RWT ranked at 39th and has been regularly achieving top quartile across 2018/19.

Performance is actively monitored and managed through contract review and use of contractual levers. Local scrutiny and action planning, including targeted investment through the A&E Delivery Board is helping to ensure Wolverhampton A&E performance is ahead of others in the region.

## **A&E 12 Hour Trolley Waits**

There were six instances of A&E patients waiting in excess of 12 hours in 2018/19, all breaches were investigated and reported at RWT's Contract Review Meetings. All of the breaches were in relation to mental health patients and a joint table top review has been carried out between the CCG, Mental Health and Acute Trusts to review the cause of the delays, lessons learnt and to agree mitigating actions.

## **Ambulance Handovers**

Although ambulance handover times at RWT have not achieved the national standard, the position throughout the year has been better than at many other acute providers. The month on month increase ambulance conveyances (13% during the months of February and March 2019 compared with the same periods last year) has added activity in to an already pressurised system. This equates to an additional 17 ambulances per day, this extra activity has meant that handovers do not always take place within 15 and 60 minutes respectively.

## **Cancer Waits**

The Cancer Recovery Action Plan is continually reviewed and performance is monitored and discussed weekly. Actions and milestones are reviewed at monthly Cancer recovery meeting and also at the monthly Contract Quality Review Meeting and Contract Review Meeting. Oversight takes place at the CCG's Finance & Performance Committee, Quality & Safety Committee and Governing Body.

Weekly meetings (alternate via conference call and face to face) discuss areas of concern and review current performance. RWT, WCCG, NHS Improvement (NHSI), NHS England (NHSE) and the Cancer Alliance are all in attendance.

The key challenges in Wolverhampton are:

- Urology capacity; demand for Robotic-assisted laparoscopic radical prostatectomy surgery is still outstripping availability, including referrals from out of area due to patients choosing the robot for their procedure. The pathway has been revised and from February RWT implemented the 28 day faster diagnosis pathway in Urology, the effects of which will be seen towards the end of March.
- Late tertiary referrals; significant numbers of tertiary referrals are being received from other trusts after the recommended day 38 of the patient's pathway.

- Radiology capacity; recent demand and capacity analysis by NHS Intensive Support Team (IST) has identified a shortfall of MRI capacity; solutions are being investigated at a Black Country STP level. Additionally, there is a national shortage of radiographers which impacting on RWT's ability to recruit additional staff.
- Month on month increase in referrals is outstripping current capacity at RWT.

### **Health Care Acquired Infections**

There were two cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia during the year in September 2018 attributed to WCCG.

There have also been two cases of MRSA at RWT during the year in May and July 2019 which were not WCCG patients.

Root Cause Analyses were presented to the Serious Incident Scrutiny Group for review and challenge of the provider to evidence actions taken to mitigate the likelihood of recurrence.

As per nationally published data for the year 2018/19, there have been 44 cases of Clostridium difficile (C. diff) for WCCG patients across all providers which is below the threshold set for the CCG of 70 in total.

As a provider there have been 31 cases of C.Diff at RWT in 2018/19, which is also below the threshold set for RWT of 34 for the year.

The CCG continues to monitor C. diff infections closely through monthly quality and safety reviews and have worked hard to tackle what is essentially a clinical issue. This has been demonstrated by the year on year reduction in cases of C. diff since 2015/16.

### **Mental Health**

\*\* At the time of reporting, nationally validated data for the Improving Access to Psychological Therapies (IAPT) standards (EH1, EH2, EA3, EAS2) is currently only available for February 2019. Data for March 2019 will be published by NHS Digital on the 13<sup>th</sup> June.

#### **IAPT - People who have entered treatment as a proportion of people with anxiety or depression (EA3)**

The primary purpose of this indicator is to measure improvement in access rates to psychological therapy services via the national Improving Access to Psychological Therapies (IAPT) programme for people with depression and/or anxiety disorders.

This indicator measures the proportion of people that enter treatment against the level of need in the general population i.e. the proportion of people who have depression and/or anxiety disorders who receive psychological therapies and it is expected that IAPT services will achieve the 19% access rate by the end of 2018/19.

Validated published CCG level data gives a performance of 16.7% for the year to date (period April 18 to Feb 19). Locally available data from our main provider suggests that the CCG will reach the year-end target of 19% however this position will not be confirmed until data from all providers is published in June following validation by NHS Digital.

## What we've done

### Joint health and wellbeing strategy

WCCG is actively involved in the delivery of Wolverhampton's Joint Health and Wellbeing Strategy, in line with our duties under section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007. The strategy has been refreshed this year to address identified local health and social care needs and considers what the members of the Health and Wellbeing Board can do in collaboration to contribute towards the City's vision of being a thriving City of opportunity. Over 1200 local people responded to a consultation on the strategy.

The key priorities for the joint Health and Wellbeing Board are to support people to grow well, live well and age well. Examples of these are:

**Growing well** - Working to improve children and young people's mental health

**Living well** - Supporting people to stay healthy throughout their working lives, and helping people stay in work when they experience health problems (mental or physical)  
- Enabling people to live longer and healthier lives by helping them change their lifestyle and improving the environment in which they live

**Ageing well** - Health partners working together more effectively, in particular, for people who are frail or at the end of life  
- Working together to enable the City to be Dementia Friendly for people living with Dementia and their families.

The Health and Wellbeing Board consists of representatives across health, social care, and the voluntary sector – including Healthwatch, the business community, police and fire services. The CCG is a statutory member of the Board and actively contributes to the development of city-wide policies and initiatives to reduce some of the stark gaps in health experienced across the city. Dr Helen Hibbs, the CCG's Accountable Officer and Steven Marshall, Director of Strategy and Transformation are the CCG's representatives on the Health and Wellbeing Board and they provide feedback on the work of the Board to the Governing Body as well as supporting the Board to understand how the work of the CCG contributes to the delivery of the strategy.

### Joint Strategic Needs Assessment (JSNA)

This year Public Health colleagues have been collaborating with the CCG and wider partners in the Wolverhampton Integrated Care Alliance. In particular, Public Health have provided strategic input around population health intelligence; using data that is available about patterns of health and disease, levels of health and social care service usage and outcomes. This information has been used to support clinical leads to consider where changes can be made to the current system that would help to improve outcomes across the population.

### Reducing health inequalities

Having the best start in life, an excellent education, a stable rewarding job and a decent home in a thriving community are the strongest factors that influence both how long a person is likely to live and their quality of life. We believe that getting these factors right, coupled with enabling access to high quality health and care services, will have a significant impact on the behaviours, lifestyle choices and health of our residents. Only by working in partnership across the 'whole system,' on strategic, longer term goals, can we achieve good

health for our population. In particular we seek to accelerate improvements in health for those groups which are most disadvantaged.

### **Improving flu-uptake in school children**

One of the significant successes of this year's collaborative efforts has been our work with CWC Public Health and Communications teams, alongside RWT, to develop the 'flu fighters' campaign aimed at school children eligible for flu vaccine (Reception to Year 5). The local 'flu fighters' story was circulated to 28,000 children across the City, along with a digital video sequence, to creatively engage young children and families with the importance of flu vaccination. Overall uptake in school children this year has risen from the lowest to the highest in the Black Country, and we have seen the highest improvement across every year group within the West Midlands region.

### **Increasing access to NHS Health Checks**

The NHS Health Check is an essential component of national CVD prevention strategy, and has been a focus for CWC Public Health and WCCG this year. By working together through a new joint commissioning model, we have simplified and standardised the logistics of the health checks invitation and delivery arm within primary care, and have enabled practices to really scale up their provision of health checks across the City. Since April 2018, our cumulative % of eligible adults who have received a health check has risen from 11% to 41%, putting us close to our target of top-quartile performance nationally (48%) within a year of implementing changes. To put this into context, we have performed almost three times as many health checks across the City this year compared to our last financial year.

### **Joint Public Mental Health and Wellbeing Strategy**

As part of an ambition to more closely align approaches to improving mental health and physical health, CWC and WCCG have worked with partners across the City to develop the Joint Public Mental Health and Wellbeing Strategy, which incorporates the Joint Mental Health Commissioning Strategy. This sets out a shared vision to improve the mental health and wellbeing of every Wolverhampton resident, recognising the work needed to meet a broader range of mental health needs across the life course.

### **Improving the quality of services**

Quality is at the heart of everything we do, as responsible commissioners we are fully committed to driving quality and improvement in services, ensuring a positive patient experience and making sure all services commissioned are safe and effective. In order to achieve this we have robust contracts, which are supported through effective governance and assurance frameworks which monitor quality and also serve to address concerns.

We are committed to:

- **Improving patient involvement, feedback and dignity:** we continue to work with the local community to hear their experiences of care; this assists the CCG to co-produce service changes that lead to more innovative practice and improvements in service provision. We have a wide range of support to enable us to do this, including our population of patient reviewers which has enabled patient representatives to accompany our visits and have worked closely with Healthwatch to undertake quality visits aligned to tools such as 'NHS 15 step challenge'

[http://webarchive.nationalarchives.gov.uk/\\*http://www.institute.nhs.uk/productives/15StepsChallenge](http://webarchive.nationalarchives.gov.uk/*http://www.institute.nhs.uk/productives/15StepsChallenge). In addition we regularly scrutinise Friends and Family test results

and patient survey feedback from provider organisations and use this information as an indicator of provider service quality and to highlight areas for improvement.

- **Ensuring a system wide approach to quality assurance and safety:** We have maintained a strong emphasis on a system-wide approach to quality assurance and safety improvement through our quality and safety strategy. Our work focuses on avoiding and reducing avoidable harm in health and care and where harm has occurred, ensuring timely, transparent reporting and robust processes to ensure local and system wide learning is critical. Learning from local and national incidents and inquiries is key to ensuring safer services for our population. Contracts with provider organisations provide a basis to drive improvement. Scrutiny of the quality of care is undertaken in a consistent way by the CCG and includes a number of quality assurance arrangements, which are used to collate and triangulate information gathered, these include formal meeting arrangements with provider organisations, announced and unannounced visits, patient and partner feedback, use of 'soft intelligence' and working in a collaborative way with regulators, including CQC, NHSE and NHSI. We also have an opportunity to share our intelligence at Quality Surveillance Group, which is a regional group convened to share best practice and escalate any particular system wide issues of concern.
- **Ensuring Primary Care services deliver safe high-quality care:** Under our delegated commissioning responsibilities we have strengthened and developed processes for assurance and development. We are working in collaboration with Primary Care colleagues to ensure robust reporting systems, timely responses to issues and ensuring appropriate action and learning should incidents occur.
- **Commissioning and delivering services that are compliant with National Institute for Health and Care Excellence (NICE) guidance and quality standards:** improvements in medicine and treatment are made available to patients in line with national guidance. This enables the most up to date and effective care and treatment to be provided to treat the conditions our patients are experiencing. A monthly NICE Assurance Group meeting is held with our providers in order to provide the CCG with assurances regarding the implementation of NICE guidance. To ensure medications are prescribed in line with NICE we have commissioned the use of BlueTeq, which provides us with assurance that patients are being offered the most appropriate treatments in line with NICE TAGs. It also provides us with assurances patients being treated with NICE approved treatments are being routinely reviewed in line with recommendations. Our providers are asked to present us with evidence through audits to show compliance with NICE guidance. Within primary care, we have commissioned a team of pharmacists and technicians to run audits to ascertain how our primary care prescribing measures against NICE guidance and quality standards.
- **Safeguarding:** The safeguarding team ensures WCCG is able to demonstrate that they have appropriate systems in place for discharging their statutory duties in term of safeguarding. On behalf of WCCG the safeguarding team seek assurances from the organisations from which they commission services that they have effective safeguarding arrangements in place. WCCG work collaboratively with all partner agencies to ensure critical services are in place to respond to children and adults who are at risk or who have been harmed, in order to deliver improved outcomes and life chances for the most vulnerable.

## Our Care Homes Improvement Plan: Safer Provision and Care Excellence (SPACE):

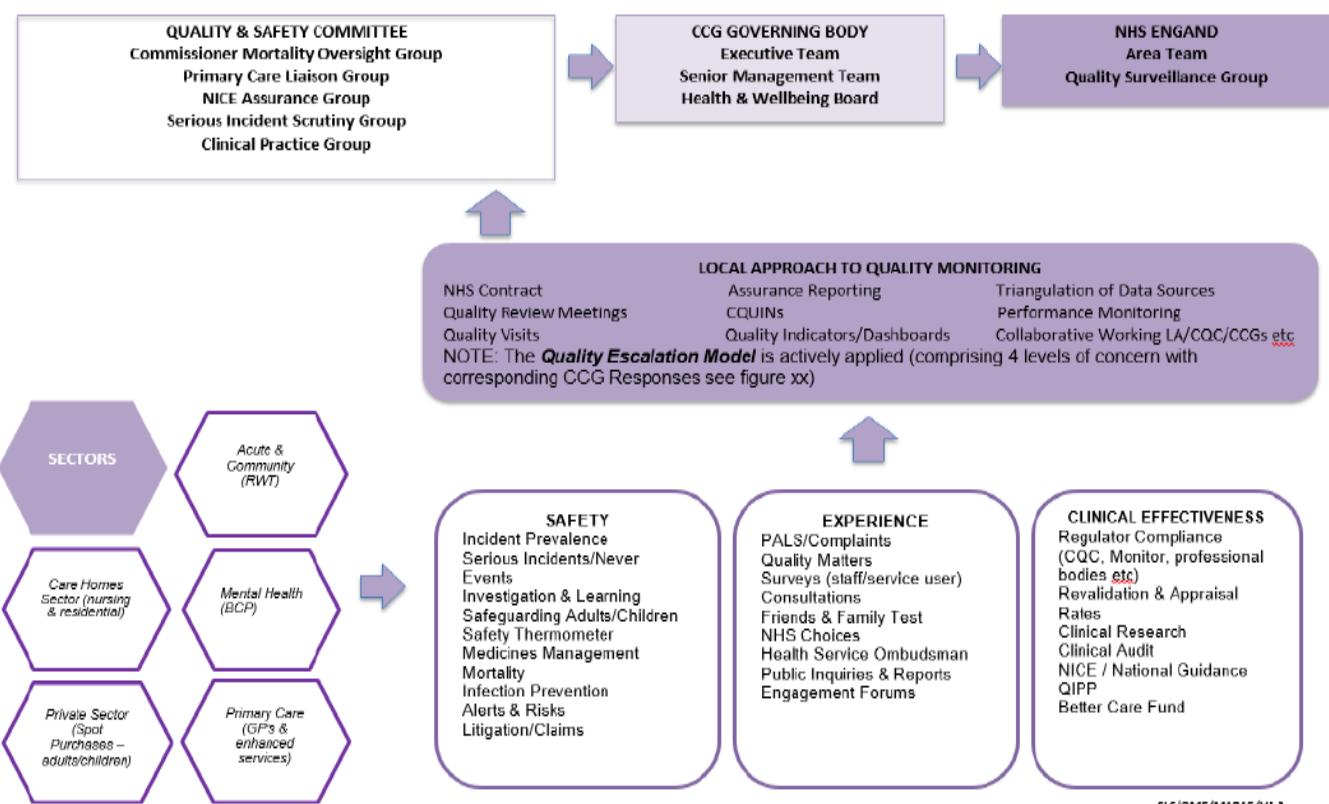
The two year formal SPACE programme has now been completed. The aim of the programme was to train staff and managers in service improvement techniques, with the aim of strengthening the safety culture and reducing adverse events. Embedding this across Wolverhampton is the legacy that will incorporate our 'sign up to safety' pledges.

Formal evaluation by West Midlands Collaboration for Leadership in Applied Health Research and Care (CLAHRC-WM) has responded positively and has agreed that this programme has strengthened safety culture and has reduced the incidence of adverse safety events. The final report is due for publication in Q4, 2018/19.

The achievements of the Care Homes who engaged with the two year programme were celebrated at a SPACE Care Home Improvement Sharing Event held in Wolverhampton in November 2018. Care Home Managers and staff shared stories of their SPACE journey and how participation in the programme had benefited their homes.

A sustainability plan has been developed in conjunction with Walsall CCG, City of Wolverhampton Council, and Continuing Health Care (CHC) and acute trust colleagues to support continuation of the programme beyond December 2018. The role of the CCG's Quality Nurse Advisors has been strengthened to include QI facilitation remit and stronger links have been forged with Public Health and Primary Care via the EHCH.

## Quality governance structure



## Patient safety

We continue to monitor serious incidents that arise involving our patients. This is now done through scrutiny groups that include our providers of healthcare services, to encourage an open dialogue. In the spirit of openness and transparency a fluid conversation takes place

regarding all root cause analyses. This enables us and our health care services to identify learning opportunities and be assured that care in those settings has been investigated to identify what went wrong and what action is required to prevent further occurrences. We strive to ensure that the care provided to our patients is as safe as possible.

We have seen four 'Never Events' reported this year and continue to work with our providers to ensure sufficient controls are in place to prevent further incidents of this type occurring again in the future. This has formed a structured programme of quality visits, both announced and unannounced, and table top reviews that have included national regulators/organisations.

## **Developing mental health services**

This year we have continued to work towards giving mental health services the same priority as physical health services across all age groups.

We have developed our Mental Health Strategy with 15 goals to describe our ambitious transformation of services in line with the Five Year Forward View for Mental Health and the NHS Long Term Plan. Our seven key priorities are outlined below.

Our implementation plan for delivery focuses on delivery of the following seven key priorities:

- **Integration of mental and physical health** – working across primary, secondary and tertiary mental health and physical care to close the mortality gap (mental health difficulties increase the risk of physical ill health). Depression increases the risk of mortality by 50% and doubles the risk of coronary heart disease in adults. People with mental health problems such as schizophrenia or bipolar disorder die on average 16–25 years sooner than the general population – (Closing the Gap 2015).
- **Improving access to evidence based quality services and improving the responsiveness of care pathways and services** – including referral to treatment and waiting times - closing the treatment gap – in line with the Five Year Forward View for Mental Health.
- **Improving Data Quality – closing the data quality gap by ensuring good, transparent, regular data and information** is collected in line with national requirements in terms of outcome reporting and recording, such as new KPIs and including use of the APRIL 17 New MH SDS, the monitoring of new access and waiting times and referral to treatment standards such as within IAPT, Early Intervention In Psychosis and Eating Disorders Services. We will ensure better and more joined-up data and outcomes reporting and harness the innovation of NHS digital to ensure fit for purpose EPR systems that are connected across mental and physical health and primary care using Graphnet for example and by also by developing NHS FLO tele-health and mental health Apps.
- **Commitment to the Mental Health Investment Standard - closing the parity of esteem / funding gap** (in addition to the Mental Health Investment Standard our commitment to parity of esteem includes adapting profiles of funding to close gaps / deliver New Models of Care and identify opportunities for system wide QIPP and value for money / reinvestment. This includes opportunities to commission collaboratively on a Black Country and West Birmingham footprint, pool expertise and resources and achieve economies of scale).
- **Improving the Wider Determinants of Mental Health – closing the early intervention and prevention gap** - including targeted mental health promotion across the lifespan and across universal services and primary secondary and tertiary

care. This will be delivered as part of our local Prevention Concordat, challenging and addressing the broader determinants of mental ill-health involving all agencies, voluntary groups and organisations that can have a strategic and day to day influence on the wider determinants of mental health.

- **An information revolution - working with all key stakeholders to ensure that together we have a joined up approach to information sharing, advice and guidance, navigation, communication, marketing and engagement,** this will include a pro-active marketing campaign aligned to national campaigns such as Heads Together, Time to Change, Health Poverty Action.
- **Developing a work force plan in line with Stepping Forward to 2020 and align with developments and initiatives across our STP to allow development of recruitment, retention and training, supervision and mentorship of all staff.** This will develop capacity and capability to support and deliver new service models, demonstrate sound processes to support and recruit staff with lived experience of mental difficulties and support the mental health and emotional well-being of all our staff.

Building on our achievements from last year in 2018/19 we have delivered the following:

For the Black Country and West Birmingham STP we continue to host Thrive into Work (a project working with the West Midlands Combined Authority that supports people with mental and / or physical health difficulties into paid employment or self-employment. This involves a research trial and is a programme of national significance. We are very proud to be supporting this project on behalf of our region.

For the Black Country and West Birmingham STP, working with the Dudley and Walsall Mental Health Partnership Trust (DWMHT), we have applied for and successfully received NHS England transformation funding to deliver IPS (Individual Placement Support) employment support for patients across our secondary mental health services.

Working with our colleagues in the Black Country Partnership NHS Foundation Trust (BCPFT), the Voluntary Sector Council and the City of Wolverhampton Council we have developed our commissioning plans to deliver a Recovery College in 2019 supporting service users and carers of all mental health services to achieve help and support to realise personal dreams, goals and ambitions, reduce loneliness and isolation and improve access to purposeful, meaningful, leisure, educational, creative and recreational activities.

For the Black Country and West Birmingham region we successfully applied for and won NHS England Transformation funding and are now delivering a Specialist Community Perinatal Mental Health Service covering a critical gap in access to specialist care across our footprint. The specialist service is now fully operational having recruited to a service specification compliant with NICE Guidance and Royal College of Psychiatry Guidance working with Birmingham and Solihull NHS Foundation Trust, BCPFT and DWMHT.

As the second stage of this work for the Black Country and West Birmingham region we are hosting a Perinatal Mental Health Whole System programme working with the Black Country and West Birmingham Local Maternity System, scoping and mapping the requirements of our locality to provide a stepped model of care to support mothers and fathers throughout the perinatal period to maintain and develop good mental health.

We have worked with our local authority colleagues and our partners in BCPFT and DWMHT to implement our Joint Autism Strategy and we have focussed on improved access to diagnostic care pathways for adults with Autism and / or ADHD.

We have extended our commissioning of Primary Care Counselling and Core IAPT services to include additional partners and commission and deliver digital i.e. online therapy via the Big White Wall and to commence our plans to deliver IAPT for people with a long-term condition.

We have successfully applied for A&E Delivery Board funding working with our colleagues in the City of Wolverhampton Council to employ social care and welfare rights staff in our Mental Health Urgent and Planned Care Pathways to ensure that patients receive benefits advice and support and that out of hospital placements in nursing care and supported accommodation are accessed in a timely and productive manner.

Across primary and secondary care we have worked with GPs and BCPFT to improve / increase access to essential Physical Health Checks for people with severe and enduring mental illness.

We have worked with BCPFT to commission and deliver 24/7 Mental Health Liaison and Crisis Resolution Home Treatment Services.

We have worked with our partners Accord to commission CCG fully funded Step-Down / Step-Up Beds for people who require additional support post discharge from hospital and people who require support to achieve stable housing.

We have worked with our partners to develop our Mental Health Stakeholder Forum and develop our Mental Health Strategy, along our themes of being a Lamp, Lifeboat and Ladder. We have been engaging with the general public and our service users and carers to develop a commissioning outcomes framework, and our Mental Health and Equalities Group (hosted and chaired by BCPFT) to focus on achieving improved access and culturally competent services and services that support the needs of all people with protected characteristics under the DDA.

We have worked with our partners in BCPFT to deliver the new access and waiting time standards for Eating Disorder Services and the Early Intervention in Psychosis Service to support compliance with NICE Guidance.

We have successfully applied for A&E Delivery Board funding to support and work with our colleagues in the Voluntary Sector Council and the Positive Action for Mental Health Group (PA4MH) to refresh the Mental Health Services Directory and provide designated support to our Self-Help Groups across our City, aiming to reduce isolation and loneliness and support improved access to all mental health support across primary, secondary and tertiary care and universal services.

We are working with our colleagues in BCPFT to implement the shared care record Graph Net across primary and secondary care.

Working with our colleagues in the City of Wolverhampton Council, BCPFT, RWT and the Dementia Action Alliance we have developed a Dementia Strategy – with a plan to transform and develop services in line with our 15 goals of the Mental Health Strategy.

We have worked with our partners across our Mental Health Stakeholder Forum to deliver our programme of mental health awareness on World Mental Health Day, thus supporting our ambition to reduce stigma and increase access to information about mental health services.

We have continued to develop our Urgent and Planned Mental Health Care Pathways as part of our Better Care Fund programme working with the Voluntary Sector Council the City of Wolverhampton Council and BCPFT to deliver the Wolverhampton Crisis Concordat, reduce Out of Area Treatments (OATs), provide targeted support for high volume service

users and support for people with mental health and alcohol and substance misuse difficulties i.e. Dual Diagnosis and deliver the Wolverhampton Prevention Concordat ensuring that early intervention and prevention and mental health promotion is delivered across universal services and primary, secondary and tertiary care.

To ensure that, wherever feasible, people from Wolverhampton can access care as close to home as possible, we have continued to work with providers and colleagues within the City of Wolverhampton Council to commission community services based care pathways and care packages that provide safe, sound and supportive care for people of all ages. At the same time, we have focussed upon bringing patients closer to home where they are currently being cared for outside of Wolverhampton. This is to improve patient and carer experience and outcomes, and to commission services in a way that will improve value for money and financial sustainability and allow for re-investment in more locally based care.

This includes our work to support the Transforming Care Programme agenda for people with a Learning Disability and/or Autism to ensure that out of hospital care is provided wherever possible.



## **Child and Adolescent Mental Health**

This year we have continued to work towards developing a comprehensive child and adolescent mental health transformation plan to ensure that services across the city can meet the needs of our young people moving forwards.

We have refreshed our Child and Adolescent Mental Health (CAMH) Transformation Plan 2018-2020 to give a clear description of the transformational work that has taken place to date and what the intentions are regarding the committed investment the CCG is to receive for the next few years to ensure we are able to meet the needs of our young people.

We have jointly procured an Emotional Mental Health and Wellbeing service with City of Wolverhampton Council and HeadStart from the Children's Society (the service is known as BEAM, Wolverhampton) as well as procuring an online counselling service from Kooth to meet the needs of young people. These services have supported filling the gap in provision that has been longstanding in Wolverhampton for lower intensity emotional mental health and wellbeing services and they have been available in Wolverhampton since April/May 2018. Since this time, the Single Point of Access (SPA) has been further developed with staff from the specialist CAMH service and Beam, together triaging the referrals received. We are continuing to work with our partners in BCPFT, The Children's Society known as BEAM Wolverhampton and Kooth to deliver the new access standards for CYP Mental Health which expects that by 2020-21 at least 35% of CYP with a diagnosable MH condition will receive treatment from an NHS-funded community mental health service.

In order to improve clinical outcomes, funding was re-aligned into the CAMH Service crisis and home intervention team from the Key Team, to ensure that children and young people in crisis, results in either prevention/reduction in hospital admissions and also ensures that there is better liaison between inpatient and community services. This funding will be used to also increase access for these children and young people to services.

We have secured funding into specialist provision to ensure that the needs of our most complex children and young people are met and ensures that the quality of mental health provision is of a high standard.

Looking forward into 2019/20, the child and adolescent mental health services will look to implement the transformation plan, working with the City of Wolverhampton Council to ensure that all aspects of the plan meet the needs of children and young people. Further to this we have planned to develop and re-specify local community services to improve responsiveness and referral to treatment times. Across the model there will be a focus on intervening early and maintaining a correct level of support to ensure that people stay well and maintain recovery. This will include services for children and young people with a learning disability and / or autism as we continue to work with local partners to deliver our Transforming Care Plan. The plan will involve working closely with Local Authority colleagues across SEND and Social Care to develop the portfolio and pathway of services that offer support to children, young people and families with ASD and LD and specialist residential care.

To ensure that, wherever feasible, children and young people from Wolverhampton can access care as close to home as possible, we work with providers and colleagues within the Local Authority to commission community services based care pathways and care packages that provide safe, sound and supportive care for people of all ages. At the same time we will focus on bringing children and young people closer to home where they are currently being cared for outside of Wolverhampton. This will improve their experience and outcomes. We also commission services in a way that will provide quality services, good outcomes for the children and young people and improve value for money and financial sustainability.

## Digital transformation journey

WCCG has pursued a strategy to identify and adopt new technologies. We have continued to be involved with new technologies and were selected as one of the beta sites for the NHS App. We are also one of the first areas to implement GP online Triage and GP online video consultation.

We have continued to migrate from Windows 7 to Windows 10 and are on course to complete the migration to the new operating system before Windows 7 goes end of life on 14 January 2020.

The CCG has also been a key driver in the development of joint working across the Black Country and West Birmingham STP and has implemented an STP wide SharePoint file sharing solution. This is used by a number of teams across the STP and supports integrated working and the development of solutions across the whole Black Country.

For the coming year we have a large portfolio of work. These include the provision of an updated patient arrival and booking solution, the update looks to improve the existing solution to updating the software from local isolated media players and touch screen to a centrally managed cloud estate using Jayex Connect.

We have successfully bid for additional funds to support the development of the Insight Shared Care Record (Wolverhampton Shared Care Record) and are working with Walsall CCG to combine the two records into a single instance.

Working with the Black Country and West Birmingham STP we have successfully bid and received funding to upgrade our electronic document management solution (Docman) to the latest cloud based solution.

## Service changes this year

Service changes as a result of procurements:

2018/19 has been another busy year in regard to procurement activity within the CCG, ably supported by NHS Arden and Greater East Midlands Commissioning Support Unit. During the course of the year the CCG has undertaken a number of procurement projects, with a summary of these as follows:

### Alternative Provider Medical Services (APMS)

WCCG holds three Alternative Provider Medical Services (APMS) contracts that expire on the 31 March 2019. Last autumn, the CCG conducted a procurement exercise for the re-provision of these services. The procurement was conducted in two lots as follows:

- Lot 1 - Pennfields Health Centre
- Lot 2 - Bilston Urban Village and Ettingshall Medical Centre in Wolverhampton.

Key objectives of the Procurement were to commission the services to serve the Wolverhampton area and:

- Provide primary care services which will be accessible, convenient and responsive, protecting patient dignity and respect;
- Design services around the needs of patients and carers, ensuring they are offered more choice and a greater say in their treatment, promoting healthy living and tackling the causes of ill health.

The contract was awarded in early December 2018 to Health and Beyond Ltd who secured both lots. The contract will be in place for five years from 1 April 2019 with the option to extend for a further five years.

### **Continuing Healthcare – Care Home Framework**

This procurement process provides an opportunity for local care homes to apply to be part of the CCG's framework, which gives a guaranteed price in return for delivery of a service which adheres to a robust specification with defined quality standards. In utilising the Any Qualified Provider (AQP) mechanism, there is no guarantee of activity to providers and therefore they are 'zero value' contracts. Selection is largely determined by patient choice.

An advertisement was placed in December 2018 inviting applications accordingly. This is the fourth time this has been advertised to potential providers in the past three years. The evaluation process is due to be completed by the end of February 2019, with successful bidders due to be informed in April 2019.

### **Community Equipment Loans Service**

In June 2018, the CCG's Commissioning Committee supported a decision to procure the local Community Equipment Loans Service (for health related equipment). This mainly covers the provision of beds and the associated mattresses, cushions and accessories.

In October 2018, a mini-competition process was commenced via the Health Trust Europe framework agreement for the supply of pressure area equipment, Lot 9 – medical beds and related services.

Following a robust evaluation process, the contract was awarded to Drive DeVilbiss Sidhil Ltd. The contract term is 36 months commencing from 1 April 2019 with an option to extend for a further 24 months.

It is expected that the following clinical benefits will result from this change in provision arrangements:

- Reduced incidence of higher-grade pressure ulcers together with more effective management and prevention of pressure ulcers among patients at risk
- Better management of long-term conditions (LTCs) that require equipment support
- Fewer patients admitted to acute care and/or care homes as a result of pressure ulcers and other LTCs
- Improved standards of infection prevention leading to reduced risk of cross-infection from contaminated equipment.

Service changes in primary care

### **Primary Care Counselling Service**

A Primary Care Counselling Service was established during 2017 and originally put in place as a six month pilot. The pilot service was awarded to an organisation called Relate, based in Birmingham.

In October 2017, the committee received a report summarising the evaluation findings and based on those findings it was agreed to extend the pilot service until March 2018. A further report was brought to the committee in January 2018 recommending a longer term service be established due to further success of the pilot, which was evidenced by improved outcomes to service users. It was agreed to conduct a mini procurement with suitably qualified providers (including the incumbent) with the offer of a three year contract with effect from 1 April 2018.

A local procurement was undertaken accordingly and the highest scoring bid was a consortium bid submitted by Relate Birmingham, in partnership with Aspiring Futures CIC, The Disability Resource Centre, Base 25 and The Haven. A three year contract has been in place from 1 April 2018.

### **Extended access to primary care**

There have been a number of exciting developments and improvements in the provision of access to Primary Care appointments within Wolverhampton. The four groups of GPs in Wolverhampton (Wolverhampton Total Health, Wolverhampton Care Collaborative, Unity and Vertical Integration), which are made up of different GP Practices working together, have delivered key improvements for patients and these have been positively recognised by NHS England following an assurance visit.

Patients are able to access appointments from 6:30pm – 8:00pm on Monday to Friday and access is also provided on Saturdays, Sundays and Bank Holidays (hours determined by the groups) at four hubs in different geographical locations in Wolverhampton. Routine and urgent clinical appointments are both available within these hubs, and specialist clinics are also available at some of these sites. These include Diabetes Clinics and NHS Health Checks.

Currently, over 2700 additional primary care appointments are available each month across Wolverhampton. The utilisation rate of these appointments is approximately 85% as the number of appointments available has grown over the year. Over the Christmas period all four hubs offered appointments on Christmas day, Boxing Day and New Year's Day, making Primary Care Services easier to access for Wolverhampton patients over the busy bank holiday period. The hubs offer various types of appointments with GPs, Advanced Nurse Practitioners, Pharmacists and Practice Nurses. Appointments have been advertised widely to encourage patients to book rather than waiting to see a GP at their usual practice.

The CCG has been working to extend access to online services for patients. Pilots are currently being undertaken to support the roll out and development of online services (triage and consultation) and these services are in addition to a wider plan that also includes raising awareness of prescription ordering, online booking of appointments and improved patient access. Alongside this, the introduction of a two way texting system for practices and patients to use has led to reduced DNA rates as text reminders are now sent to patients.

### **Special Access Service**

During 18/19, the CCG has also commissioned a Wolverhampton practice to provide a Special Access Service to deliver general medical services for patients who have displayed violent behaviour and been removed from a practice list.

## **Home visits**

The CCG is currently piloting a service whereby highly skilled nurse prescribers in the community are carrying out home visits for patients residing in Wolverhampton that are unable to get to the surgery.

The service is due to be evaluated, but early signs show it is proving successful in releasing GP time to care for other patients in surgery, and providing a high quality home visiting service for those patients who can't get to the surgery.

## **Engaging people and communities**

### **Commissioning Intentions**

The setting of Commissioning Intentions is an annual activity that seeks to ensure that commissioners have a clear oversight for delivering their on-going vision for improving local health outcomes.

A communications and participation plan was put together (using the engagement cycle) and monitored by the Commissioning Intentions Group to inform clinicians and staff within our organisations, partner organisations, patient/community groups and the public about the engagement exercise and how to get involved to share with us their views.

We held two meetings during 2018 with our PPG Chairs and our Citizens Forum Group where we discussed three areas: mental health services; primary care and hospital services. We asked participants four questions which were discussed at length at their tables.

- What is good?
- What is ok but could be better?
- What is bad?
- How could things be improved?

We share these results to the group and in the form of a 'You said – We did' document available on WCCG website. <https://wolverhamptonccg.nhs.uk/contact-us/you-said-we-did>

**Children's services** - In June 2018 we attended a Wolverhampton SEND event to engage with parents and carers about their experiences of health services across the city. Information gathered at the event will help to shape future commissioning.

**Skin (Dermatology) services in Wolverhampton** - During January and February 2019 we asked Wolverhampton residents' views about dermatology (skin) services. We asked participants to tell us their current and past experiences, share their views and help shape the future design of community dermatology services in Wolverhampton. We held two focus groups and shared an online survey to gather opinion. We will use the feedback we receive to inform the decisions we make on how community dermatology services are provided in Wolverhampton.

**Prescribing over the counter medicines** - In August 2018 we engaged with members of the public on reducing prescribing of over the counter medicines for minor, short-term health conditions.

We set up a survey to ask people their views on whether medications that are available to buy over the counter should continue to be available on prescription. We promoted the survey via our online channels and attended two groups across the city to do some targeted engagement. The groups we attended were a respiratory group and an older people's group.

180 people completed the survey. You can read the summary report  
<https://wolverhamptonccg.nhs.uk/hidden-publications/2477-self-care-with-over-the-counter-medicines-survey-results/file>

To support and implement the changes, we have distributed posters and leaflets to GP practices to be displayed in their waiting areas. You can also view them here  
<https://wolverhamptonccg.nhs.uk/publications/listening-to-patients/2478-prescribing-of-over-the-counter-medicines-is-changing-leaflet>  
<https://wolverhamptonccg.nhs.uk/publications/listening-to-patients/2479-self-care-poster>

**Medicines of Limited Clinical Value** - In August 2018 we asked for views about the future of medicines with limited clinical value.

We created a survey and attended two groups across the city to do some targeted engagement with people who are already on long term medication of some description, to understand their views.

93 people completed the survey. You can read the summary report  
<https://wolverhamptonccg.nhs.uk/hidden-publications/2480-medicines-of-limited-clinical-value-survey-results/file>

## Sustainability Transformation Partnership (STP) and Long Term Plan (LTP)

**Mental health** – During May 2018 we held a Black Country Mental Health Summit. Working in partnership with our communication colleagues in the STP and mental health providers, we met to start to look at how some mental health services could be commissioned and delivered on a Black Country footprint, rather than on a CCG area. The results of this piece of work have been taken forward as part of the STP Mental Health workstream.

**Transforming Community Care Partnership (TCP)** – Planning began in autumn 2018 to work with STP partners and to plan to engage with public in March 2019 around the new community model in each area and the proposal for the Black Country specialist beds.

**LTP** – we are engaging and updating our staff monthly about the implementation of the LTP and what it means for the ways we are working together in the future. We have shared our future five and ten year planning, key priorities, the importance of financial stability, how our place based alliance work is developing and how we will work even closer with our colleagues in Public Health around prevention. We will continue working with our GP members as they develop their Primary Care Networks. We have discussed the key priorities. We will continue to engage with our staff over the coming months and their comments will influence some of the changes necessary to deliver the LTP.

**Place based commissioning** - Wolverhampton Integrated Care Alliance (ICA). On 31 January the first of a series of engagement events for the ICA was held for clinicians and managers from City of Wolverhampton Council, Wolverhampton Clinical Commissioning Group, Wolverhampton Primary Care, The Royal Wolverhampton Hospitals Trust and Black Country Partnership Foundation Trust. The event held at The Molineux Stadium was well attended by over 70 stakeholders. Attendees heard about what the ICA will mean for the

organisations involved and also heard about work beginning on the first four clinical workstreams.

## Feedback mechanisms

We receive concerns, compliments and comments via our many communication channels; these are then fed back to our Quality and Safety and Commissioning teams in the CCG. These channels are our website, local media and social media. It is also via these outlets that we inform the public about the outcomes of our engagement work and how public and patient views have informed our decisions. Our Lay Member for Public and Patient Involvement represents public and patient views at our Governing Body meetings, and ensures that we are fulfilling our obligations in relation to engagement and consultation.

Listening and acting upon the feedback that patients and the public have taken time and effort to share is very important to us. Some of the information patients have given to us has been used to influence our commissioning as part of the Commissioning Engagement Cycle.

## Public and stakeholder involvement groups

We encourage people to get involved in shaping the services that we commission by giving them the opportunity to attend a range of involvement groups. These include:

**Patient Partner Scheme** – Our Patient Partner Scheme is a free membership scheme that provides interested local people with information about new health initiatives and how they can share their views by taking part in events and consultations. The public can fill in an online or paper form to join up and can let us know which areas they are most interested in learning about.

**Patient Participation Groups and Citizen's Forum** – Over the past year our PPG Chairs and Citizen's Forum groups have continued to meet bi-monthly to share our current local and national projects. The Citizen's Forum Group is made up of community leaders from faith, disease specific groups and local community groups. At these joint meetings we informed and updated them on WCCG workstreams. We have taken time this year to embed the new models of Primary Care that evolved during last year, share the ongoing work for the GP Five Year Forward View and share information around the new Primary Care Networks. We also feedback any of their issues to the Governing Body through our Lay Member.

**Joint Engagement Assurance Group** – We continued to meet quarterly to share engagement opportunities across the city with our stakeholders and provide assurance to the engagement framework effectiveness.

## Annual General Meeting (AGM)



On Wednesday 25 July we held our AGM. Over 50 members of the public attended, along with CCG senior members, GP's, partners from local groups and other organisations, as well as clinicians, our staff and local stakeholders.

We paid tribute to NHS 70 throughout the event and showcased the CCG's achievements over the last 12 months. These include improvements to GP services with the development of our New

Models of Care and good collaborative working with our partners in Wolverhampton and across the Black Country. It also gave us the opportunity to announce our 'Outstanding' rating from NHS England. We are proud to be one of only three CCG's in the country to have received the top rating three years in a row.

We finished the afternoon with a 1940s-themed celebration with afternoon tea and music from the era. Attendees also had an opportunity to talk to CCG representatives and ask any questions. Our feedback from those who attended has been extremely positive and we are really pleased that so many enjoyed the afternoon.

## NHS70 Celebrations

On Friday 6 July, the CCG and City of Wolverhampton Council invited people to join them to celebrate NHS 70 at Sainsbury's supermarket in the city

*"Robert wouldn't be alive without the NHS – finest organisation in the world. First class service."*

Vanessa and Robert

We celebrated the special birthday with a tea party in the café, with health and social care guests.

We shared information on how people can help the NHS work effectively and people pledged to do their bit to ensure resources are used responsibly.



Members of the public shared their experiences of the NHS and it was great to hear people's positive stories of how the NHS has looked after them over the years.

We also celebrated NHS70 with a tea party at our AGM in July. Many of our GP practices also held tea parties of their own, supported by their PPGs.

## Campaigns

**Winter** - This campaign, which was an output of the Wolverhampton A&E Delivery Board, started in October 2018 and completed March 2019. It had a dual focus of encouraging our target audiences to stay well, and to choose appropriately when in need of urgent or emergency care. The objective was to reach out to, and educate groups with a higher propensity to present inappropriately at urgent and emergency care services. We promoted the new message of, Help us to help you. This year also we joined across our STP footprint in the Black Country and West Birmingham to deliver joint messages via social media and press.

Phase one from October 2018 focused on promotion of uptake of the flu vaccine to the nationally defined target groups. Here in Wolverhampton we promoted the national campaign materials through the usual channels of social media, online and press releases. We also worked with our colleagues this year in



Wolverhampton Public Health to develop a children's storybook to encourage the uptake of the free Fluenz vaccination for children. The Fluenz nasal spray is offered free to children in school nursery, Reception, Year 1, Year 2, Year 3, Year 4 and Year 5. See our website for details of the book which has been distributed to schools in Wolverhampton.

<https://wolverhamptonccg.nhs.uk/your-health-services/staywell-this-winter/flu-nasal-spray-for-children>



Phase two in November 2018 focused on winter preparedness and wellness using the Help Us to Help You branding, but the primary objective was to communicate and engage on NHS 111, Self Care and pharmacy to the targeted audiences.

**Extended GP opening hours** - Along with the national promotion, in Wolverhampton we advertised our extended GP opening hours with

a bus campaign on both the rear of buses and on the inside of buses. We also promoted extended GP appointments online through AdMessenger. Running since the end of October, there have already been over 200,000 impressions leading to over 8,000 hits on the Primary Care Extended Hours page on the CCG website.

<https://wolverhamptonccg.nhs.uk/primary-care/gp-extended-opening-hours>. This page was also advertised via social media and via the front page of the website.



**Self Care** – over the counter medicines During December we worked with the Medicines Management team to design and print material around how the prescribing of over the counter medicines has changed. The material included leaflets, posters, checklists for GPs and receptionists and pull up banners. The material was distributed to GPs and pharmacists in January to help support and promote the changes to the public. We also created a Self Care page on the CCG website to encourage people to manage their conditions where possible and to provide them with useful resources: <https://wolverhamptonccg.nhs.uk/your-health-services/self-care>

**Patient Access App** - Promotion of the Patient Access App is on a variety of media and sites. These include social media, promotion at Molineux Stadium digitally and printed, printed materials and online.



**Choose Self Care**

NHS  
Wolverhampton Clinical Commissioning Group

Many common health conditions can be safely treated at home without a prescription.

Your GP, nurse or practice pharmacist will not normally give you a prescription for common, short-term, easily treated, health conditions. Medicines for these conditions are available to buy Over the Counter in a pharmacy or supermarket/shop.

**For advice and information:**

- Ask at your local pharmacy (they can offer free advice)
- Call NHS 111 for advice, available 24/7 and free of charge from any phone or mobile
- Visit the NHS website for a Health A-Z ([www.nhs.uk](http://www.nhs.uk))

**Wolverhampton Clinical Commissioning Group**  
Technology Centre, Wolverhampton Science Park, Glaisher Drive, Wolverhampton, WV10 9RU  
Telephone: 01902 444878  
Website: [www.wolverhamptonccg.nhs.uk](http://www.wolverhamptonccg.nhs.uk)

A range of health conditions can be managed with Self Care – these include:

Acute sore throat	Diarrhoea (adults)	Head lice	Occasional migraine	Mild dry skin	Nappy rash	Sun protection
Conjunctivitis	Dry eyes/ tired eyes	Indigestion and heartburn	Insect bites and stings	Mild occasional dermatitis	Oral thrush	Teething / mild toothache
Cough, colds and blocked nose	Ear wax	Infant colic	Mild acne	Mild to moderate hay fever	Prevention of tooth decay	Threadworms
Cradle cap	Excessive sweating	Occasional cold sores of the lip	Mild burns and scalds	Minor pain, discomfort and fever*	Ringworm / athletes foot	Travel sickness
Dandruff	Haemorrhoids	Occasional constipation	Mild cystitis	Mouth ulcers	Sunburn	Warts and verrucas

\* (e.g. aches and sprains; headache; period pain; back pain)

A pharmacist can also give advice on Probiotics, Vitamins and Minerals.

**Heatwave advice** - Late June saw temperatures across England soar to dangerous levels and a Level 2 warning issued by The Met Office. Communications via press, online, electronically and social media were circulated to public and staff to remind them about how to take care, and shared tips to stay safe in the sun and high temperatures.

**Cold weather alert warnings** - During January 2019 we released a press release and regular tweets whenever we have had a weather warning to inform the public about how to stay well in the colder weather.



Dr Helen Hibbs  
Accountable Officer

21 May 2019

# ACCOUNTABILITY REPORT

## Members report

### Our member practices

Practice Name	Address
<b>Dr Agarwal and Partners</b> Duncan Street Primary Care Centre	Duncan Street, Blakenhall Wolverhampton, WV2 3AN
<b>Dr S Agrawal and Partners</b> Tudor Medical Practice <b>BRANCHES</b> Wellington Road Surgery Leicester Street Medical Centre Owen Road Surgery	1 Tudor Road, Heath Town Wolverhampton, WV10 0LT
<b>Dr D Bagary and Partners</b> MGS Medical Practice <b>BRANCHES</b> 30-32 Ruskin Road Wallace Road	191 First Avenue, Low Hill Wolverhampton, WV10 9SX
<b>Dr R Bilas</b>	75 Griffiths Drive, Ashmore Park, Wednesfield, WV11 2JN
<b>Dr Burrell and Partners</b> Penn Manor Medical Centre	Manor Road, Penn Wolverhampton, WV4 5PY
<b>Dr D Bush</b> Penn Surgery	2a Coalway Road, Penn Wolverhampton, WV3 7LR
<b>Dr M Manley and Partners</b> The Surgery	119 Coalway Road, Penn Wolverhampton, WV3 7NA
<b>Dr A Nandanavanam</b> Ashfield Road Surgery <b>BRANCH</b> Pendeford Health Centre	39 Ashfield Road, Fordhouses Wolverhampton, WV10 6QX
<b>Dr J Fowler</b>	470 Stafford Road Wolverhampton, WV10 6AR
<b>Dr R Rajcholan</b> Ashmore Park Health Centre	Griffiths Drive, Ashmore Park Wednesfield, WV11 2LH
<b>Dr A Johnson and Partners</b> Parkfield Medical Practice <b>BRANCH</b> Woodcross Health Centre	255 Parkfield Road, Parkfields Wolverhampton WV14 0EE
<b>Intrahealth Ltd</b>	Bankfield Road, Bilston

Bilston Urban Village Medical Centre	Wolverhampton WV14 0EE
<b>Intrahealth Ltd</b> Pennfields Medical Centre	Upper Zoar Street, Pennfields Wolverhampton, WV3 0JH
<b>Dr M Ashton and Partners</b> Tettenhall Medical Practice <b>BRANCH</b> Wood Road	Lower Street Tettenhall Wolverhampton, WV6 9LL
<b>Dr K Ahmed and Partners</b> IH Medical	Prouds Lane, Bilston Wolverhampton, WV14 6PW
<b>Dr F Jones and Partners</b> Woden Road Surgery	Woden Road, Tettenhall Wood Wolverhampton, WV6 8NF
<b>Dr M Kainth</b> Primrose Lane Health Centre	Primrose Lane, Low Hill Wolverhampton, WV2 3BT
<b>Drs M Kehler and Partners</b> Keats Grove Surgery	7 Keats Grove, The Scotlands Wolverhampton, WV10 8RN
<b>Dr R Kharwadkar</b> Fordhouses Medical Centre <b>BRANCH</b> Pendeford Health Centre	68 Marsh Lane, Fordhouses Wolverhampton, WV10 8LY
<b>Dr K Krishan and Partners</b> Mayfields Medical Centre <b>BRANCH</b> Cromwell Road Surgery	272 Willenhall Road Wolverhampton, WV1 2GZ
<b>Dr C Libberton and Partners</b>	60 Cannock Road Wednesfield, WV10 8PJ
<b>Dr G Mahay</b> Poplars Medical Practice	122 Third Avenue, Low Hill Wolverhampton, WV10 9PG
<b>Dr S Mittal</b> Probert Road Surgery	Probert Road, Oxley Wolverhampton, WV10 6UF
<b>Dr C Luis and Partners</b> Prestbury Medical Practice <b>BRANCH</b> Bushbury Health Centre, Hellier Road	81 Prestwood Road West Wednesfield, WV11 1HT
<b>Dr N Mudigonda</b> Bilston Health Centre	Prouds Lane, Bilston Wolverhampton, WV14 6PW
<b>Dr J Parkes and Partners</b> Alfred Squire Road Health Centre	Alfred Squire Road Wednesfield, WV11 1XU
<b>Ettingshall Medical Centre (RWT)</b>	Herbert Street, Ettingshall Wolverhampton, WV14 0NF
<b>Dr G Pickavance and Partners</b> The Newbridge Surgery	255 Tettenhall Road Wolverhampton, WV6 0DE

<b>Dr S Ravindran and Majid</b> East Park Medical Centre	Jonesfield Crescent, East Park Wolverhampton WV1 2LW
<b>Dr A Stone and Partners</b> Thornley Street Surgery	40 Thornley Street, Wolverhampton, WV1 1JP
<b>Dr M Sidhu and Partners</b> Lea Road Medical Practice	35 Lea Road, Pennfields Wolverhampton, WV3 0LS
<b>Dr A Sharma</b> Bilston Family Practice	Prouds Lane, Bilston Wolverhampton, WV14 6PW
<b>Dr S Suryani</b> The Surgery	Hill Street, Bradley Wolverhampton WV14 8SE
<b>Dr M Sidhu and Partner</b> West Park Surgery	Park Road West, Tettenhall, Wolverhampton, WV1 4TF
<b>Dr P Venkataraman and Partners</b> Grove Medical Centre	175 Steelhouse Lane Wolverhampton, WV2 2AU
<b>BRANCHES</b>	
Caerleon Surgery, Dover Street All Saints & Rosevillas, 17 Cartwright St All Saints & Rosevillas, 1 Shale Street Bradley Medical Centre, 83-84 Hall Green Street Church Street Surgery, 62 – 64 Church Street	
<b>Drs Vij and Vij</b> Whitmore Reans Health Centre	Lowe Street, Whitmore Reans Wolverhampton, WV6 0QL
<b>BRANCHES</b>	
Pendeford Health Centre Ednam Road Surgery	
<b>Dr P Wagstaff and Partners</b> Castlecroft Medical Practice	Castlecroft Avenue Wolverhampton WV3 8JN
<b>Dr N Whitehouse</b> Tettenhall Road Medical Practice	199 Tettenhall Road Wolverhampton, WV6 0DD
<b>Drs A Williams and Partners</b> Warstones Health Centre	Pinfold Grove, Warstones Wolverhampton, WV4 4PS
<b>Wolverhampton Doctors On Call Ltd</b>	Fifth Avenue Wolverhampton, WV10 0HP

## **Composition of Governing Body**

The Governing Body is responsible in law for ensuring that the CCG exercises its functions effectively, efficiently and economically in accordance with the principles of good governance. It does this by leading on the setting of the vision and strategy, budgets and commissioning plans for the organisation to ensure services are commissioned effectively in order to achieve our vision of delivering the right care, in the right place at the right time.

During 2017/18 we altered the structure of our Governing Body to include representation from the GP Groups operating in Wolverhampton and held elections for the GP positions. The membership of the Governing Body during 2018/19 has been:-

**Chair** – Dr Salma Reehana

**Accountable Officer** – Dr Helen Hibbs

**Other elected GP members:**

Representing ‘Unity’ (Medical Chambers Group)

- Dr David Bush
- Dr Manjit Kainth
- Dr Rajshree Rajcholan

Representing Primary Care Home 1 Group

- Dr Mohammad Asghar

Representing Primary Care Home 2 Group

- Dr Rashi Gulati

Representing Vertical Integration Group

- Dr Julian Parkes

**Chief Finance Officer** – Tony Gallagher

**Director of Strategy and Transformation** – Steven Marshall

**Chief Nurse** – Sally Roberts

**Director of Operations** – Mike Hastings

**Lay Member for Audit and Governance** – Peter Price

**Lay Member for Finance and Performance** – Les Trigg

**Lay Member for Public and Patient Involvement** – Sue McKie

**Practice Manager Representative** – Helen Ryan

**Secondary Care Consultant** – Amarbaj Chandock (resigned October 2018)

**Co-opted Deputy Chair** - Jim Oatridge OBE

In addition, non-voting observers include Strategic Finance Officer – Matt Hartland, the Local Medical Council, CWC, Health and Wellbeing Board and Local Healthwatch representatives also routinely attend Governing Body meetings.

Our Secondary Care Consultant, Mr Amarraj Chandock resigned from the Governing Body in October 2018 and we will work to recruit to this vacancy during 2019/20.

## Governing Body Attendance

		Left early 10 April 2018	Left early 8 May 2018	Left early 22 May 2018	Left early 10 July 2018	Left early 11 September 2018	Left early 13 November 2018	Left early 12 February 2019	Left early 26 March 2019
<b>Clinical ~</b>									
Dr Manjit Kainth		✓	✓	✓	✓	✓	✓	✓	✓
Dr David Bush		✓	✓	✓	✓	✓	✓	✓	✓
Dr Julian Parkes		✓	✓	✓	✓	X	X	✓	✓
Dr Rajshree Rajcholan		✓	✓	✓	✓	✓		✓	✓
Dr Salma Reehana		✓	✓	✓	✓	✓	✓	✓	✓
Dr R Gulati		✓	✓	✓	✓	✓	X	X	✓
Dr M Asghar	X	✓	X	✓	✓	X	✓	✓	X
<b>Management ~</b>									
Mr Mike Hastings		✓	✓	✓	✓	X	X	✓	✓
Dr Helen Hibbs	X	✓	✓	✓	✓	✓	✓	✓	✓
Mr Steven Marshall		✓	✓	✓	✓	✓	X	✓	✓
Mr T Gallagher		✓	✓	✓	✓	✓	✓	✓	✓
Mr M Hartland		✓	✓	✓	✓	✓	✓	X	X
<b>Lay Members/ Consultant ~</b>									
Mr Amartaj Chandock		✓	✓	X	✓	X			
Mr Jim Oatridge		✓	✓	✓	✓	✓	✓	✓	✓
Ms Sue McKie	X	✓	✓	✓	✓	✓	✓	✓	✓
Ms Helen Ryan		✓	✓	✓	X	✓	✓	✓	✓
Mr Peter Price		✓	✓	✓	✓	✓	✓	✓	✓
Mr L Trigg		✓	✓	✓	✓	✓	✓	✓	✓

## Audit and Governance Committee members

The Governing Body is required to appoint an Audit and Governance Committee, chaired by the Lay Member for Audit and Governance. The committee's other members are independent lay members with significant experience of audit and financial matters:

- Peter Price (Chair)
- Jim Oatridge OBE (Deputy Chair)
- Les Trigg
- Dean Cullis

Full details of the membership of the other Governing Body committees can be found in the Governance Statement. Details of the members and work of the Remuneration Committee can be found in the Remuneration Report.

## Governing Body register of interests

Details of the interests held by members of the Governing Body are available on our website at <http://www.wolverhamptonccg.nhs.uk/about-us/declaration-of-interests>.

## Personal data-related incidents

There have been no Serious Untoward Incidents relating to data security breaches by the CCG, including any that were reported to the Information Commissioner.

Data security breaches by other organisations that the CCG has become aware of have been reported to the relevant organisations to manage within their own reporting structures.

### **Statement of Disclosure to Auditors**

For each Governing Body member at the time the report is approved:

- so far as the Governing Body member is aware, there is no relevant audit information of which the CCG's auditor is unaware
- they have taken all the steps they should have taken to make themselves aware of any relevant audit information and to establish that the CCG's auditor is aware of that information.

### **Member engagement**

The relationship between our Governing Body and GP membership is crucial to the CCG's success. We are keen to foster effective engagement and ownership of our plans by our GP member practices and work with them to ensure that the patient voice is reflected throughout the process.

The makeup of our Governing Body reflects the GP groupings working in the City to develop innovative new ways of delivering Primary Care. The groups are also supported by dedicated management resource within our Primary Care Team who work closely with GPs in the groups to support the delivery of our Primary Care strategy.

Our quarterly Members meetings provide an opportunity for member practices to contribute to the developing clinical priorities across the City. During the year, topics have included the developing STP programme, work across the Black Country to respond to GP workload challenges and the configuration of the CCG's local Quality Outcomes Framework (QOF+). We also continue to use a range of strategies to communicate with practices including updating by email, e-newsletter and through our intranet.

We have continued with our programme of collaborative contract and performance monitoring with our member practices. This involves colleagues from Local Authority public health. This approach continues to be valued by practices and we are working closely with them to refine the process to ensure the visits work effectively to provide appropriate assurances. Practices are also working in their groups to discuss best practice on referrals into secondary care and we have undertaken specific work to support practices around cancer referrals during the year that is helping to support the overall programme of work to deliver improvements in cancer services. Meanwhile, our nationally recognised Quality Matters reporting site is used by member practices to share healthcare experiences with the quality and safety team.

We also hold regular 'Team W' – GP and practice staff protected learning time – educational events. These are used to keep practices updated on new developments and to discuss pathway redesign and provide a forum for high quality training events on key issues for practice staff. We continue to discuss the agenda and structure of these sessions with clinical representatives to ensure that it is relevant and attendance is maximised.

### **Modern Slavery Act**

Wolverhampton CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2019 is published on our website at <https://wolverhamptonccg.nhs.uk/about-us/modern-slavery-statement>.

## **Statement of Accountable Officers responsibilities**

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Dr Helen Hibbs to be the Accountable Officer of Wolverhampton CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money,
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section 14R of the National Health Service Act 2006 (as amended)),
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual by the Department of Health and Social Care have been followed, and disclose and explain any material departures in the financial statements; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.
- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.



Dr Helen Hibbs  
Accountable Officer

21 May 2019

## **Governance Statement**

### **Introduction and context**

NHS Wolverhampton Clinical Commissioning Group is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The clinical commissioning group's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2018, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006. As an organisation, the clinical commissioning group has not only developed a strong record of accomplishment of delivery of our statutory responsibilities and strategic objectives but demonstrated the capacity for growth – taking on additional responsibilities for the commissioning of Primary Medical services from NHS England and a leading role in developing improved and integrated health and social care, across Wolverhampton and the wider Black Country through our leading role in the STP Partnership. This is only possible through the development and maintenance of our robust systems of financial management and internal control that are described in this 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 clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.

### **Governance arrangements and effectiveness**

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

The Clinical Commissioning Group Constitution contains the following statement regarding Principles of Good Governance:

"In accordance with section 14L(2)(b) of the 2006 Act, the group will at all times observe "such generally accepted principles of good governance" in the way it conducts its business.

These include:

- a) the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;
- b) The Good Governance Standard for Public Services;
- c) the standards of behaviour published by the Committee on Standards in Public Life (1995) known as the 'Nolan Principles'
- d) the seven key principles of the NHS Constitution;
- e) the Equality Act 2010."

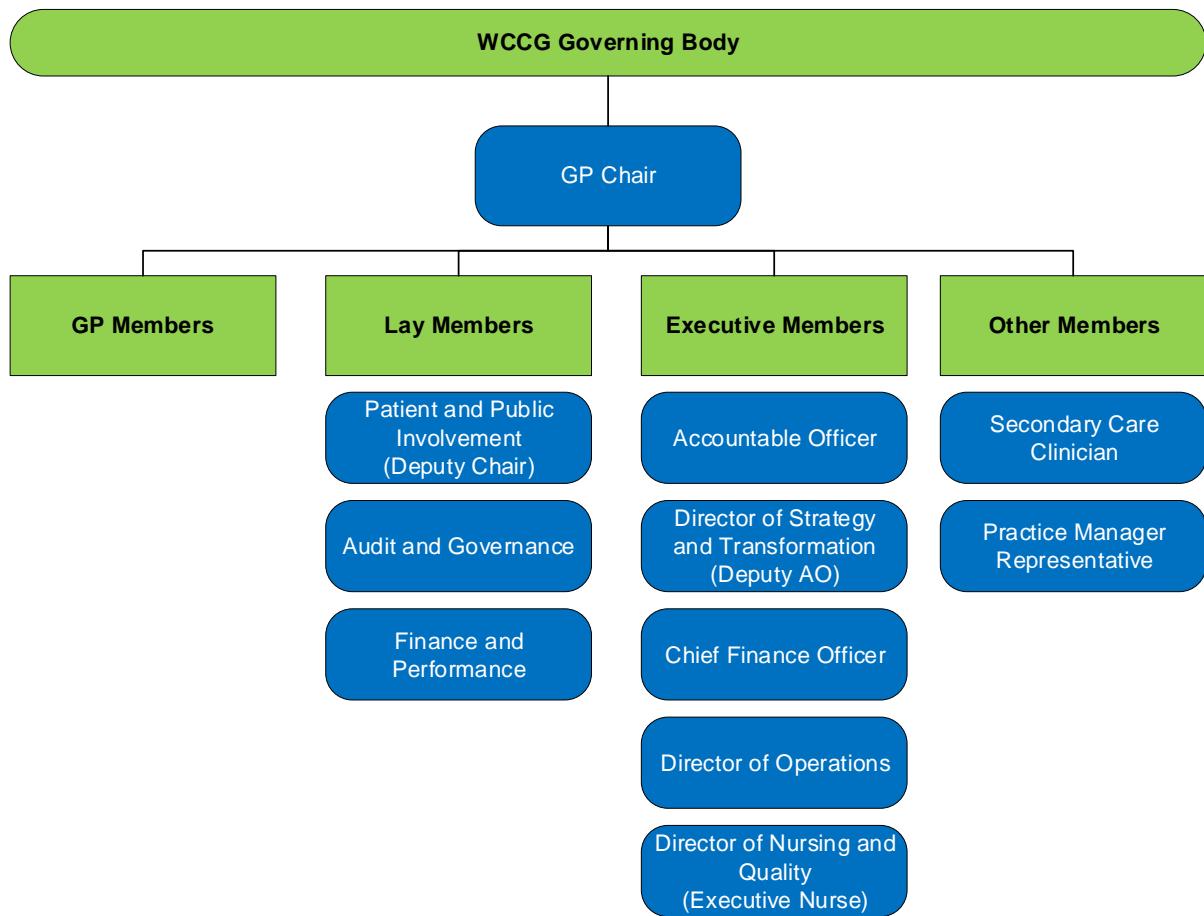
Independent Committee Members are governed by the NHS Code of Accountability and Executive Directors by the Code of Conduct for NHS Managers. As part of the NHS Code of Accountability, all Governing Body members declare any relevant interests on a public register of Declarations of Interest.

The Clinical Commissioning Group upholds the Seven Principles of Conduct in Public Life known as the Nolan Principles<sup>1</sup> and consequently all Governing Body Members are duty bound to abide by them.

Our membership is currently constituted of 40 practices across Wolverhampton. The Governing Body acting on their behalf includes seven elected GP Members including the Chair, Executive Members, Lay members, Practice Manager and Secondary Care Specialist. In total, the Governing Body consists of 17 members, of which five are executive and 12 are non-executive. The structure is shown on the next page.

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<sup>1</sup> - *Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, and Leadership.*



The Deputy Chair of the Audit Committee also attends Governing Body as a Lay Member on an Interim basis.

In addition, non-voting Observers from the Local Medical Council, City Council, Health and Wellbeing Board and Local Healthwatch also routinely attend Governing Body meetings. The GP members of the Governing Body are elected to reflect the way our membership have grouped together to develop new models of care in line with the Forward View. Further detail on the make-up of the Governing Body and attendance rates at Governing Body meetings can be found in the membership report in the CCG's Annual Report.

There are six Committees of the Governing Body within the Clinical Commissioning Group, each having delegated responsibilities:

- Audit & Governance
- Commissioning
- Finance & Performance
- Primary Care Commissioning<sup>2</sup>
- Quality & Safety
- Remuneration

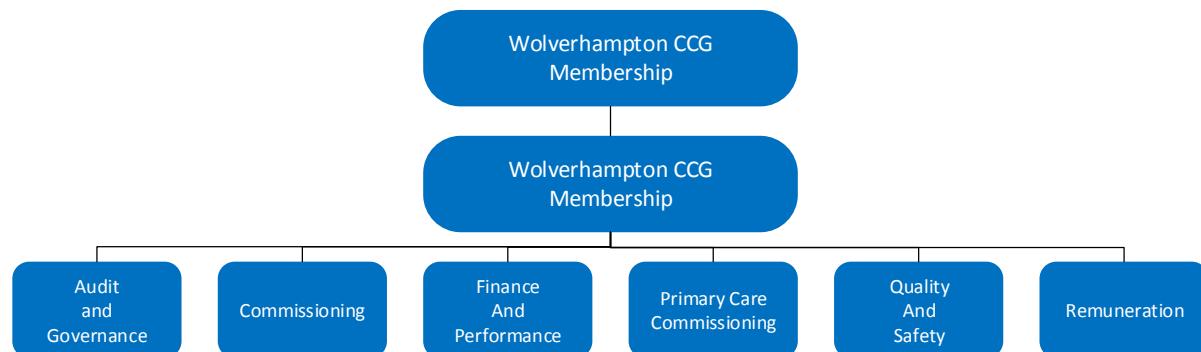
Both clinical and non-clinical members of the Governing Body sit on each of the committees, which also have additional members from within the CCG and from other organisations (the clinical members of the Primary Care Commissioning Committee are non-voting). Each

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<sup>2</sup> The Primary Care Commissioning Committee exercises the powers delegated to the CCG from NHS England in respect of Primary Medical Services.

committee has an agreed Terms of Reference and established membership which are set out in the group's constitution which is published on the CCG website.

The structure of the Committees of the Clinical Commissioning Group is detailed below:



Each of the Committees has produced an Annual Report, which are considered by the Governing Body and published. These reports contain details of the membership and attendance records for the committee and list the standing items that have been managed by that committee throughout the year as well as highlighting other items of note.

The **Audit and Governance Committee**, as highlighted later in this statement, has a key role in the Group's risk management strategy. During the year it has fulfilled this role by maintaining an overview of the development of the Clinical Commissioning Group's risk register and Governing Body Assurance Framework (GBAF). This has included considerations of Deep dives into individual GBAF domains undertaken by the Senior Management Team. It has also continued to support the development of the CCG's governance framework, including reviewing the Group's policy and procedures around whistleblowing. The Committee has also received reports on compliance with the UK Corporate Governance Code as a reference point for good practice. The committee has also maintained an overview of developing approaches to closer working with the other CCGs in the Black Country to commission services across the STP footprint.

The other Governing Body committees manage risks associated with their areas of responsibility in the course of their work by developing their own risk profile and escalating risks to the Governing Body as appropriate. In terms of their individual areas of responsibility, the **Commissioning Committee** has supported the Governing Body in the delivery of its statutory responsibilities as a commissioner of healthcare. This has included continuing to monitor and develop the Group's strategic approach to commissioning, in particular how the programme of work to deliver Quality, Innovation, Productivity and Prevention (QIPP) targets aligns with these strategies.

The **Finance and Performance Committee** has provided the Governing Body with assurance around action taken to address identified issues and underlying risks relating to the group's finance position as well as the assurance provided to NHS England that the Group has met its financial planning requirements. It has also maintained an overview of performance against relevant targets (including NHS constitutional standards) and action taken to address issues. In support of this work, the committee has worked to review and revise the way in which information is reported to it, in order to ensure it is able to focus on areas of highest priority. The Committee is also responsible for monitoring the Group's performance against its statutory duty to reduce inequalities and has received assurance on work to achieve this.

The **Primary Care Commissioning Committee** exercises the functions delegated to the CCG on behalf of NHS England in relation to the commissioning of Primary Medical

Services. During the year, this has included making decisions on requests for practices to merge, sub-contracting their services and closing branch surgeries. In line with national statutory guidance on managing conflicts of interest, the Committee has a Lay Chair, a non-clinical majority and the GP members do not have voting rights. During the year, the Group has agreed to delegate responsibility for monitoring the implementation and development of the Group's Primary Care strategy to the Committee. When the group next submits an application to vary its constitution, this change will take effect and the committee will be renamed the 'Primary Care Committee'.

The **Quality and Safety Committee** provides the Governing Body with assurance that the services commissioned by the group are of high quality and promote a culture of continuous improvement. It also maintains, on behalf of the Governing an overview of a number of significant and potentially high risk issues, including Safeguarding and Information Governance. Where necessary, it has escalated issues for consideration by the Governing Body and provided assurance on action taking place. During the year, the committee has identified and managed risks associated with cancer performance targets and mortality levels at the group's largest provider, RWT. In addition to the assurances received in respect of these matters at committee meetings, further assurance has been given at Governing Body directly.

The **Remuneration Committee**, in addition to its statutory role has delegated responsibility from the Governing Body for the approval of Human Resources Policies. These ensure that the group has an appropriate framework in place to deliver its responsibilities as an employer.

### **UK Corporate Governance Code**

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice. This Governance Statement is intended to demonstrate the Clinical Commissioning Group's compliance with the principles set out in Code and the Audit and Governance Committee keeps this under regular review.

For the financial year ended 31 March 2019, and up to the date of signing this statement, we complied with the relevant provisions set out in the Code and applied the principles of the Code. Steps have been taken during the year to address minor issues identified through the Audit Committee's review process, these are detailed throughout the statement.

### **Discharge of Statutory Functions**

In light of recommendations of the 1983 Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

### **Risk management arrangements and effectiveness**

The Clinical Commissioning Group has put in place a comprehensive structure of controls to co-ordinate and manage risk within the organisation. This consists of lines of accountability

through which issues of risk can be discussed and the effectiveness of our risk management arrangements assured.

These controls are underpinned through an integrated governance approach to examine the risks to our strategic and operational objectives, using the same methodology no matter the nature and context of the risk. This approach enables us to manage risk in an identical way across services and provides a uniform method of assurance.

Corporate responsibilities for the Governing Body, myself as Accountable Officer, the other Directors, Heads of Service and all staff are set out in the CCG's Risk strategy as well as the specific roles for the Chief Finance Officer, Director of Operations and Corporate Operations Manager. The strategy also sets out the relevant aspects of the following committees' terms of reference:

**Audit and Governance Committee** is responsible for leading the risk management process, taking a strategic view of governance, giving directions to the other Clinical Commissioning Group committees and groups regarding management of risk and receiving assurance from these Groups where NHS Standards are being achieved/not achieved.

It keeps under active review the content of the corporate risk register, addressing corporate issues, and provides assurances to the Board that directorates and departments within the Clinical Commissioning Group are managing their risks effectively.

The Audit and Governance Committee fulfils this role as part of its overall responsibility for scrutiny and verification of the CCG's corporate governance in accordance with the requirements of standing financial guidance and the requirements of the annual Statement on Internal Control.

**The Commissioning Committee, Finance and Performance Committee, Primary Care Commissioning and Quality and Safety Committees** are responsible for managing the risks under their areas of responsibility. They will, with the support of the CCG Managers who report to the committees, review and manage the risks under their areas of responsibility and escalate any risks to the Governing Body as they deem appropriate.

The risk management arrangements recognise that it is impossible to eliminate all risks but the overall philosophy of risk management in the CCG is to actively identify risk(s), analyse them and ensure that all reasonable control measures have been considered, identified and applied to mitigate the risk. This is achieved through all teams ensuring that they have undertaken risk profiling to determine the profile of risks within their portfolio so that the Clinical Commissioning Group will seek to eliminate and control all risks which have the potential to:

- harm our staff, service users, visitors and other stakeholders;
- have a high potential for incidents to occur;
- result in loss of public confidence in us and/or our partner agencies;
- have severe financial consequences or which would prevent us from carrying out our functions on behalf of our residents.

To achieve this, the arrangements highlight that a robust, continuous risk assessment process is essential, requiring clear arrangements for identifying recording and reviewing risks and set out processes to achieve this based upon clear principles to be adopted by risk handlers. These processes analyse the likelihood, consequence and controllability of the identified risk to rate the risk using a 'Red, Yellow, Amber and Green' scale to determine action to be taken. They also highlight that individual managers and heads of service are responsible for profiling risks within their areas of responsibility and set out arrangements for escalating increasing risks or those not progressing satisfactorily.

As a general principle the Clinical Commissioning Group has determined the following levels of risk:

### **Acceptable Risks**

Risks in the low (green) category are considered to be an “Acceptable risk” and their existing controls are regularly monitored. Consideration may be given to a more cost-effective solution or improvement that imposes no additional cost burden.

### **Moderate Risks**

Risks in the medium (yellow) category are considered to be a “Moderate risk” and they are actively monitored with steps taken where necessary to prevent them from escalating. The costs associated with any actions will be weighed against the likelihood and impact of any event.

### **Unacceptable Risks**

Risks in the high (amber) categories are considered to be “Unacceptable risks” and efforts are made to reduce the risk, weighing up the costs of prevention against the impact of an event.

### **Significant Unacceptable Risks**

Risks in the highest (red) category will be considered to be “Significant risks” and immediate action must be taken to put in control measures to manage the risk. A number of control measures may be required involving significant resources to reduce the risk. Where the risk involves work in progress urgent action should be taken.

The overall risk management strategy is also supported by specific arrangements to identify and manage risks in key areas. This includes a robust counter fraud strategy and whistleblowing protocols and work continues to ensure risk management is embedded across the organisation. All formal committee papers include sections that require report authors to assess both risk implications and the relevant domains within the assurance framework.

### **Capacity to handle risk**

The Clinical Commissioning Group’s risk management philosophy makes it clear that risk management is a collective responsibility owned across the organisation. Within this context, operational responsibility for risk management is assigned to the Corporate Operations Manager who is responsible for ensuring clear processes for recording and managing risks are in place and that teams are effectively supported in using them.

The outcome of the risk management philosophy is that risk is seen as the responsibility of every member and employee of the Clinical Commissioning Group. Risk is owned at all levels and there is a robust challenge system in place at Senior Management Team level as well as Directors and Committees.

The Risk Management Strategy aims to provide the Clinical Commissioning Group with a framework for the development of a robust risk management framework and related processes throughout the organisation. The risk management strategy has been reviewed and endorsed by the Audit and Governance Committee during the year.

The CCG cannot manage its risks effectively unless it knows what the risks are. All directors & heads of service are responsible for ensuring their teams are briefed on the policy and that the processes contained within it are actively implemented and embedded. Therefore, all

teams will hold a risk profile and maintain a team risk register to encompass all risks the service faces. Risks identified at this level will be assessed against team objectives in the first instance.

Where teams consider that risks they have identified need to be brought to the attention of the appropriate Committee they inform the Corporate Operations Manager who arranges for the risk to be added to the Committee Risk Register. The Committee then assesses the risk to determine the assessment at team level remains appropriate when assessed against broader organisational objectives. Once the Committee has considered the risk it will ensure that the risk is appropriately reviewed and, if necessary, escalated to the Governing Body for further attention and assessment if required. The Operations Team are responsible for developing a programme of training and support on how teams effectively identify and manage risks. Emphasis is placed upon understanding the level at which a risk needs to be managed and, the objectives that the risk impacts on. For risks managed at Committee or Governing Body level all risks are aligned to their impact on the Clinical Commissioning Group's Governing Body Assurance Framework, to enable the responsible committees and Governing Body to regularly review the influencing factors from new risks and their impact on the control measures for the respective assurance framework domain(s). One of the domains within the Governing Body Assurance Framework is the CCG continuing to meet its statutory duties and responsibilities, enabling the CCG to assess the risk of the CCG not meeting its statutory obligations in a timely manner.

## Risk Assessment

This is directly linked to the Clinical Commissioning Group Risk Management Strategy (outlined above) and is underpinned by challenge from responsible committees and Internal Audit. The Governing Body maintains the overall oversight of the group's performance, tasking the Finance and Performance committee to undertake specific detailed support in this area.

There are no Corporate level Red risks that are currently open at the end of the year that have implications for governance. There is one Red risk currently open at the end of the year with implications for governance on the Quality and Safety Committee's risk register as follows:

- **The Royal Wolverhampton Trust Cancer Performance** - If patients are waiting in excess of the 62 day cancer waiting time standard and have a recorded waiting time of more than 104 days there is a risk of clinical harm and poor patient experience. The CCG is working closely with RWT and NHS England and Improvement to implement actions to recover performance including reviewing long waiting patients and tracking lists. A Recovery Plan is in place and monitored weekly the CCG is challenging RWT to ensure set trajectories will be met.

## Other sources of assurance

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

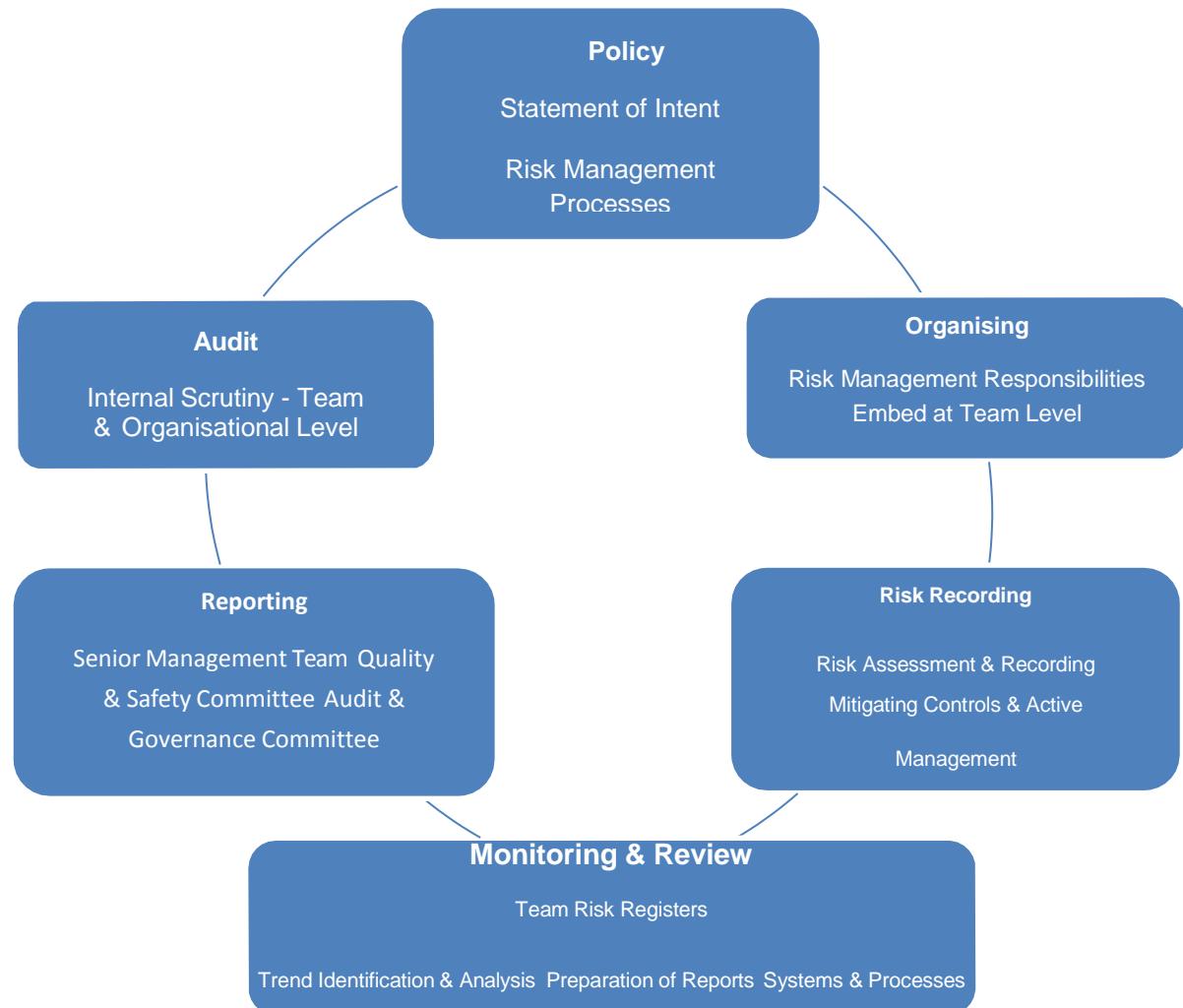
The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The Clinical Commissioning Group has a set of processes and procedures in place to ensure it delivers its policies, aims and objectives and this is audited internally. It is designed

to identify and prioritise risks, 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 CCG's system of internal control is supported by effective use of appropriate electronic systems to ensure information is effectively recorded and reported throughout the organisation as appropriate. As highlighted above, this is based on the principles outlined in the risk management framework which clearly articulates the relevant roles and responsibilities of key individuals and teams as well as the overall corporate responsibilities of all staff. These overall arrangements are summarised in the diagram below:

#### *Internal Control Framework*



#### **Annual audit of conflicts of interest management**

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

The CCG's internal audit review of conflict of interest management followed the national template and included details of how the CCG had implemented revisions in the statutory guidance from NHS England. The report included one low risk finding that the most up to

date Conflict of Interest policy should be published on the CCG website and this action has been implemented. The CCG also response to a self-assessment of its management of conflicts of interests which forms part of NHS England's Improvement and Assessment Framework. The CCG has confirmed it is fully compliant with these arrangements.

## **Data Quality**

The Clinical Commissioning Group employs Lancashire and Midlands CSU to provide data and analysis. The CSU has provided the following statement:

"The CSU is committed to maintaining high standards in its management of data, working in accordance with best practice to provide appropriate assurance regarding data quality. The CSU recognises its statutory responsibilities in relation to the quality and management of data under the Data Protection Act 1998, the Freedom of Information Act 2000, and associated Legislation.

The underlining principles to our data quality are as follows;

- Accuracy – Data should be sufficiently detailed for the purposes for which It is collected.
- Validity – Data will be collected and used in compliance with internal and external requirements, to ensure consistency and it reflects the intended requirements.
- Reliability – Data is collected and processed consistently and in accordance with our defined processes to ensure that any changes in data are genuinely reflective of the activities represented;
- Timeliness – Data is collected as promptly as possible after the associated activity and be available for use within a reasonable timeframe;
- Relevance – Data collected should be relevant for the purposes for which they are obtained;
- Completeness – Data should be complete and as comprehensive as necessary to provide an accurate representation of the activity concerned and meet the information needs of the customer.

In addition, depending on data sources required additional validation rules are applied within processing to improve the accuracy of the data for use in reporting, for example stage 1 and 2 validations within acute data.

All outputs are quality assured through our integrated Quality Assurance Process."

Our data security arrangements are subject to proportionate penetration testing in partnership with our IT Service Provider, RWT. In line with the service level agreement we have in place with RWT, the CCG's network infrastructure is maintained in line with national 'Cyber Essentials' standards this and other investment by RWT ensures that high levels of preparedness (which ensured no patients were impacted during the 2017 WannaCry incident) are maintained. The risk of Cyber attacks remains as a live risk on the CCG's risk register.

## **Information Governance**

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by NHS Digital's Data Security and Protection toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. We have submitted a satisfactory level of compliance with this year's toolkit assessment, meeting all

of the mandatory requirements and confirming that the CCG meets the 10 Data Security Standards from the National Data Guardian.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing information governance processes and procedures in line with the information governance toolkit. The Group's Information Governance policy and staff handbook have been reviewed during the year to reflect national requirements. We have ensured all staff undertake annual information governance training and have a policy of spot checks to ensure staffs are aware of their information governance roles and responsibilities. Every report submitted to formal committees includes details of any information governance implications and specific issues have been considered as part of the key risks identified by the group (see below for further details).

There are processes in place for incident reporting and investigation of serious incidents. We have taken steps during the year to develop information risk assessment and management procedures and a programme is in place to fully embed an information risk culture throughout the organisation. The Quality and Safety Committee are regularly updated on the operation of the Group's Information Governance framework, including details of information security incidents, learning from 'near misses' and compliance with the Freedom of Information Act.

### **Business Critical Models**

The Macpherson Report, issued in March 2013, emphasised the importance of strong leadership which values and expects effective challenge, a clear governance framework and time for quality assurance of business critical models. The review recommendations highlighted best practice which should apply across organisations, in particular, the responsibility of the Governing Body in ensuring that an appropriate framework and processes are in place.

Whilst the review did not specifically cover the NHS, its principles and recommendations can be translated to a number of the CCG's business critical functions such as procurement of services and major transformation programmes and associated QIPP schemes. Within the CCG the principles of the Macpherson Report recommendations have been adopted. An appropriate framework and environment is in place to provide quality assurance of business critical models including transparency of reporting, a robust Freedom of Information process and a robust programme management structure to support the delivery of QIPP objectives.

### **Third party assurances**

The Group has robust measures in place to ensure that, where responsibilities are delegated to other organisations (such as the Commissioning Support Unit), assurance is provided to ensure that resources are used economically, efficiently and effectively. This includes ensuring that clear contracts are in place for the delivery of services that are then managed through the Group's contracting processes. Additionally, the Group's arrangements with Commissioning Support Unit ensure that both internal and external audit have adequate access to records to provide assurance on the effectiveness of these arrangements. In addition, as highlighted above, as part of the programme of work supporting developing proposals for collaborative commissioning the CCG has begun actively considering what assurances will be required in the future as the commissioning landscape changes and the role of the CCG shifts within more integrated system working.

## **Control issues**

The group has not identified any significant control issues during the year.

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

The organisation's economy, efficiency and effectiveness of the use of resources is the responsibility of the Governing Body. The Governing Body undertakes fulfilling this responsibility through its role in approving the CCG's operating structure and via delegation to its committees whose job it is to deliver, provide assurance to the Governing Body and be open to inspection. The Audit and Governance Committee is accountable to the group's Governing Body and its remit is to provide the Governing Body with an independent and objective view of the group's systems, information and compliance with laws, regulations and directions governing the group. It delivers this remit in the context of the group's priorities and the risks associated with achieving them. The Audit and Governance Committee is supported in this work by both Internal and External Auditors, who report regularly to the committee on the agreed work programme, which is developed using a risk based approach to ensure that there is a focus on the most appropriate areas of the group's business. The CCG has changed the provider of both internal and external audit services to ensure that a continuous impartial and objective assessment is made of these systems. The Finance and Performance Committee maintains an oversight of the work to achieve the CCG's financial duties, including ensuring management and running costs remain within the appropriate levels and escalating any matters of concern to the Governing Body as appropriate.

NHS England and the CCG are engaged in a process of continuous assessment against the national CCG Improvement and Assessment Framework. This includes monthly discussions on performance issues, an on-going work plan to provide assurance around Financial Management and scrutinised self-assessment of the CCG's governance and leadership arrangements. As part of this process Executive Directors also attend risk based checkpoint reviews with NHSE where the NHSE Area Team scrutinise the effectiveness of on-going performance. In 2017/18 NHS England rated CCGs against the CCG Improvement and Assessment Framework. The annual assessment identifies areas of strength as well as areas of challenge and improvement. The Clinical Commissioning Group was assessed overall as 'Outstanding' for the third year in a row (the only CCG in the Midlands and East Region to achieve this rating for three consecutive years). This continues to reflect high performance against the Quality of Leadership indicator as well as the CCG's on-going strong financial management arrangements based on robust planning processes that ensures the group meets its requirement to operate efficiently and effectively.

## **Delegation of functions**

As highlighted above, The Group has robust measures in place to ensure that assurance is provided from third parties where functions are delegated and continues to actively consider how this will operate in a future environment that is likely to see much greater delegation of functions in transformed health systems. Specifically, robust contracting mechanisms are in place with the Commissioning Support Unit and the Group's Pooled Fund arrangement with the City of Wolverhampton Council under the Better Care Fund is managed through a Section 75 agreement. The Section 75 agreement details the responsibilities of the local authority as the host for the Pooled Fund and the associated Governance Arrangements. This arrangement has previously been reviewed by internal auditors, concluding that substantial assurance can be given that the controls are operating effectively and has formed part of the external audit process.

No feedback has been received through these mechanisms or external reports into organisations with which the Group has delegated arrangements that provides evidence of internal control failures or poor risk management.

## **Counter fraud arrangements**

The CCG has engaged PwC to provide Counter Fraud Services. Under this arrangement, an accredited Counter Fraud Specialist undertakes counter fraud work on behalf of the CCG proportionate to identified risks. The Counter Fraud Specialist reports regularly to the Audit and Governance Committee, detailing progress against each of the Standards for Commissioners. The Chief Finance Officer is responsible for championing Counter Fraud activity across the organisation and proactively and demonstrably acts to ensure the group meets its obligations in tackling fraud, bribery and corruption.

## **Head of Internal Audit Opinion**

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The Head of Internal Audit concluded that the adequacy and effectiveness of governance, risk management and control is satisfactory. Based on the risk appetite and the internal audit plan agreed with the Group, they have substantially completed their programme of work and believe there are adequate and effective governance, risk management and control processes to enable the related risks to be managed and objectives to be met. In the completed reviews, Internal Audit identified the following medium risk findings, which are set out below. Given the nature of these findings, and the CCG's mitigating controls, they are satisfied that these do not result in a risk that the CCG's corporate objectives will not be achieved.

- **Delegated Commissioning**
  - Practices were not regularly assessed on quality, safety and performance through practice visits.
- **Audit Follow Up**
  - Sample testing identified that a medium risk rated recommendation from the 2015/16 IT Risk Diagnostic review to improve documentation beyond baseline requirements to solidify the CCG's top quartile position in System Support Capability had not been implemented.
- **Data Protection Act 2018**
  - Whilst KPIs have been established to monitor the CSU's performance, these are not sufficiently granular to allow for a robust assessment of whether the CSU has met the KPI requirements.

During the year, Internal Audit issued the following audit reports:

<b>Area of Audit</b>	<b>Level of Assurance Given</b>
Corporate Governance – Primary Care Strategy	N/a – This report was not a review of the adequacy and effectiveness of controls. A number of recommendations were made and are being taken forward.
Risk Management	Low Risk
Finance	Low Risk
Safeguarding	Low Risk
Quality and Safety	Low Risk
Provider and Stakeholder Engagement	Not yet completed
Information Governance	Low Risk
Delegated Commissioning	Low Risk
Audit Follow Up	N/a – summary of previous year's findings

### **Review of the effectiveness of governance, risk management and internal control**

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

The Governing Body Assurance Framework provides me with evidence that the effectiveness of controls that manage risks to the Clinical Commissioning Group achieving its principles objectives have been reviewed.

I have reviewed the work of both the Audit and Governance and Quality and Safety Committees in discharging their responsibilities set out in the risk management strategy. This ensures that there is robust and regular monitoring of the adequacy of the effectiveness of the system of Internal Control throughout the year, which is reported to the Governing Body on a regular basis. This review highlights the Clinical Commissioning Group's commitment to securing continuous improvement of the system and the approach to identifying and addressing any weaknesses that have been identified and as such I confirm that the systems are currently effective. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit and Governance Committee and Quality and Safety committee and the work of both Internal and External Audit.

## **Conclusion**

As Accountable Officer, I confirm that no significant internal control issues have been identified for the CCG in 2018/19. This Governance Statement is a true reflection of the CCG's position at the date of publication.



Dr Helen Hibbs  
Accountable Officer

21 May 2019

## Remuneration report (information relating to directors)

### Remuneration committee report

The Chair of the Remuneration Committee is Mr Peter Price. The other members of the Remuneration Committee in 2018/19 were as follows:

- Dr David Bush
- Dr Manjit Kainth
- Mr Jim Oatridge

The number of meetings and individuals' attendance at each are as follows:

	17.05.18	05.07.18	09.10.18	19.02.19
<b>Members</b>				
<b>Peter Price, Independent Committee Member (Chair)</b>	✓	✓	✓	✓
<b>Dr David Bush, Governing Body Member, CCG</b>	✓	✓		✓
<b>Dr Manjit Kainth Governing Body Member, CCG</b>	✓	✓	✓	✓
<b>Jim Oatridge, Independent Committee Member</b>			✓	✓

A number of individuals provided advice or services to the committee that materially assisted the committee in its consideration of matters. Three of these were from the CCG – Dr Salma Reehana (Chair), Dr Helen Hibbs (Chief Officer) and Mr Tony Gallagher (Chief Finance Officer).

The CCG also engaged the HR services of Arden & GEM CSU.

### Policy on remuneration of senior managers

Senior managers for the organisation have one of three types of contract depending on their role:

*Office Holder* – Governing Body members are engaged by the CCG on office holder contracts as advised by the legal advisors Bevan Britain and Capsticks. Their pay was determined by the national guidance published in September 2012 for lay members and GPs on the Governing Body. The Governing Body members are engaged on varying lengths of term to enable stability within the organisation and, at the end of each term, consideration will be given at the Remuneration Committee as to whether pay for each session or role requires review.

*Very Senior Manager (VSM)* – The Accountable Officer, Chief Finance and Operating Officer, and Director of Strategy and Transformation are engaged by the CCG on VSM contracts.

Salaries were established in line with the national groups for determining VSM pay in September 2012.

*Agenda for Change* – The CCG's Executive Lead for Nursing and Quality and Director of Operations are engaged by the CCG on Agenda for Change terms and conditions. Pay is in line with national pay scales and pay awards.

A mechanism for reviewing Officer and VSM pay was agreed by the Remuneration Committee in June 2014. The policies adopted provide a framework for considering any

uplift to remuneration for VSM and officer members of the Governing Body. They provide an opportunity for consideration of an annual uplift and, in addition, the VSM framework details a structure for the setting and awarding of a performance-related payment. The Committee has slightly amended this framework during the year to ensure it aligns with the CCG's Performance Development Review Policy and process for setting objectives.

### **Senior managers' performance-related pay**

The Remuneration Committee agreed in 2018/19 that a reserve for an overall maximum of 10 per cent of VSM base pay would be set aside for performance-related payment. Within the 10 per cent, 2.5 per cent is allocated to each of the four domains of the CCG Improvement and Assessment Framework:

- better health
- better care
- leadership
- sustainability.

All performance-related payments are non-consolidated.

The appraisal process for VSMs includes objective setting aligned to the four categories noted above, as well as regular review of progress. Following year end, the Chair and Accountable Officer (the line managers for the VSM posts) are required to present their case for award of payment to the Remuneration Committee. The committee holds delegated responsibility to agree any award to be made.

VSM appraisal relating to 2018/19 performance is scheduled to take place early in the new financial year with a plan for the Remuneration Committee to make a final decision regarding award by the summer.

### **Policy on duration of contracts, notice periods and termination payments**

The policy for senior manager contracts varies according to the role, for employees of the CCG:

*VSM contracts* – senior managers on VSM contracts are engaged on a permanent contract with a notice period of six months. Any termination payments will be made in line with Agenda for Change terms and conditions for severance payments.

*Agenda for Change* – senior managers on Agenda for Change contracts are engaged on a permanent contract with a notice period of three months. Any termination payments will be made in line with Agenda for Change terms and conditions for severance payments.

For Officeholder, non-Executive positions:

*Elected GP office holders* – these office holder contracts are for a tenure period of three years.

*Practice manager representative office holder* – this role has a maximum length of tenure of five years.

*Lay member and secondary care doctor office holders* – these roles have a maximum length of tenure of five years.

The notice of all office holder contracts could be terminated with immediate effect based on a number of criteria within the contract, for example, the CCG no longer requiring a role under statute.

### **Remuneration of Very Senior Managers (VSMs)**

In 2018/19 there were no individuals employed or engaged on temporary assignments by the CCG earning more than the Prime Minister's salary of £150,000 per annum.

## Pension benefits (audited)

The table below illustrates the 2018-19 pension benefits accrued by the CCG's senior managers. Note that certain members do not receive pensionable remuneration, therefore they will not have an entry in this table.

Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
<b>H Hibbs - Accountable Officer</b>	0-2.5	0-2.5	15-20	50-55	371	17	418	0
<b>T Gallagher - Chief Finance Officer *</b>	7.5-10	22.5-25	40-45	130-135	761	252	1055	0
<b>M Hartland - Strategic Finance Officer ** ~</b>	2.5-5	0-2.5	45-50	110-115	680	112	829	0
<b>D Roberts - Chief Nurse &amp; Director of Quality (commenced in post 05/02/18) ~</b>	2.5-5	10-12.5	35-40	115-120	638	145	815	0
<b>S Marshall - Director of Strategy &amp; Transformation # ~</b>	0-2.5	0	15-20	0	197	38	255	0
<b>M Hastings - Director of Operations ~</b>	0-2.5	0-2.5	15-20	30-35	202	47	266	0

These figures have been provided by the Greenbury team at the NHS Business Services Authority (NHSBSA) - note that for managers marked ~ the 2017-18 pension figures have been updated by NHSBSA resulting in minor adjustments to the figures brought forward at 1-18.

Figures are not given for GP Board Members since any pension contributions are processed by NHS England through the GP SOLO process.

As lay members do not receive pensionable remuneration there are no entries in respect of pensions for these members.

\* This member works across both Walsall and Wolverhampton CCG. Figures have been provided by Walsall CCG and represent full pension calculations relating to this member's full salary across the both organisations.

\*\* This member works across Dudley, Walsall and Wolverhampton CCGs. Figures have been provided by Dudley CCG and represent full pension calculations relating to this member's full salary across all organisations.

# no lump sum is shown since only a member in the 2008 Section NHS pension scheme.

## **Cash Equivalent Transfer Values (audited)**

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

### **Real increase in CETV**

This reflects the increase in CETV 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 scheme or arrangement).

## **Pay multiples (Fair Pay disclosure) (audited)**

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 figures have been prepared in accordance with the Hutton Review of Fair Pay implementation guidance. The median remuneration is the total remuneration of the staff members lying in the middle of the linear distribution of the total staff, excluding the highest paid director. This is based on the annualised, full-time equivalent remuneration as at the reporting period date i.e. 31 March 2019. A median will not be significantly affected by large or small salaries that may skew an average (mean) hence it is more transparent in highlighting whether a director is being paid significantly more than the middle staff in the organisation.

The banded remuneration of the highest paid member of the Governing Body in the Clinical Commissioning Group in the financial year 2018-19 was £135k-£140k, (2017-18, £130k-£135k). This was 3.7 times (2017-18 3.7 times) the median remuneration of the workforce, which was £37,570, (2017-18 £36,095).

In 2018-19, nil employees (2017-18, nil) received remuneration in excess of the highest paid member of the Governing Body. Remuneration ranged from £1k-£138k, (2017-18, £6k-£131k).

In 2018/19 all staff on Agenda for Change pay bands received a 1% consolidated pay increase. A 1% consolidated pay increase was also applied to all non-Agenda for Change posts (for example VSM and Governing Body posts). Staff were also eligible to earn an incremental uplift in line with Agenda for Change terms and conditions.

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

## Salaries and allowances (audited)

The following tables present the salaries and allowances paid to the CCG's senior managers.

Name & Title	2018/19						Total (bands of £5000)
	Salary (bands of £5000) £000	Expense Payments (taxable) (rounded to the nearest £100) £00	Performance Pay & Bonuses (bands of £5000) £000	Long-term Performance Pay & Bonuses (bands of £5000) £000	All Pension Related Benefits (bands of £2500) £000		
H Hibbs - Accountable Officer	125-130	0	10-15 #	0	0	0	135-140
T Gallagher - Chief Finance Officer *	60-65	0	0	0	170-172.5	230-235	
M Hartland - Strategic Finance Officer **	5-10	0	0	0	37.5-40	45-50	
S Roberts - Chief Nurse & Director of Quality	100-105	0	5-10 #	0	72.5-75	185-190	
S Marshall - Director of Strategy & Transformation	100-105	0	5-10 #	0	25-27.5	135-140	
M Hastings - Director of Operations	80-85	0	0	0	32.5-35	115-120	
Dr S Muneer Reehana - Clinical Chair	65-70	0	0	0	0	65-70	
Dr D Bush - GP Board Member	15-20	0	0	0	0	15-20	
Dr M Kainth - GP Board Member	20-25	0	0	0	0	20-25	
Dr R Rajcholan - GP Board Member	25-30	0	0	0	0	25-30	
Dr J Parkes - GP Board Member	15-20	0	0	0	0	15-20	
Dr R Gulati - GP Board Member	15-20	0	0	0	0	15-20	
Dr M Asghar - GP Board Member	15-20	0	0	0	0	15-20	
J Oatridge – Lay Member	10-15	0	0	0	0	10-15	
P Price - Lay Member	10-15	0	0	0	0	10-15	
L Trigg - Lay Member	5-10	0	0	0	0	5-10	
S McKie - Lay Member	5-10	0	0	0	0	5-10	
H Ryan - Board practice manager representative	5-10	0	0	0	0	5-10	
A Chandock - Secondary care consultant (left post October 2018)	0-5	0	0	0	0	0-5	

\* This officer works across both Walsall and Wolverhampton CCGs and these figures represent the proportion payable by Wolverhampton CCG. The officer's full salary across both organisations was £128k.

\*\* This officer works across Dudley, Walsall and Wolverhampton CCGs and these figures represent the proportion payable by Wolverhampton CCG. The officer's full salary across all organisations was £123k.

# Estimate - in accordance with the CCG's policy for review of VSM pay the Remuneration Committee will consider and award the bonus relating to 2018-19 early in 2019-20.

GP Board Members are paid through the CCG's payroll provider with the relevant tax and NI deducted at source. Pension contributions are processed through NHS England via the GP SOLO process and therefore pension related benefits are not reported in the table above.

As lay members do not receive pensionable remuneration there are no entries in respect of pension related benefits for these members.

2017/18						
Name & Title	Salary (bands of £5000)	Expense Payments (taxable) (rounded to the nearest £100)	Performance Pay & Bonuses (bands of £5000)	Long-term Performance Pay & Bonuses (bands of £5000)	All Pension Related Benefits (bands of £2500)	Total (bands of £5000)
	£000	£00	£000	£000	£000	£000
H Hibbs - Accountable Officer	95-100	0	10-15 #	0	7.5-10	115-120
C Skidmore - Chief Finance and Operating Officer (left post 31/05/17)	15-20	0	0	0	0	15-20
T Gallagher - Chief Finance Officer (commenced in post 01/06/17) *	45-50	0	0	0	12.5-15	60-65
M Hartland - Strategic Finance Officer (commenced in post 01/06/17) **	10-15	0	0	0	22.5-25	35-40
S Roberts - Chief Nurse and Director of Quality (commenced in post 05/02/18)	15-20	0	0	0	2.5-5	20-25
M Garcha - Executive Lead for Nursing & Quality (left post 22/10/17)	50-55	0	0	0	22.5-25	75-80
S Marshall - Director of Strategy & Transformation	100-105	0	10-15 #	0	35-37.5	150-155
M Hastings – Director of Operations	75-80	0	0	0	42.5-45	120-125
Dr S Muneer Reehana – Clinical Chair wef 11/10/17 - GP board member prior to that date	40-45	0	0	0	0	40-45
Dr J Morgans - GP Board Member (left post 13/11/17 to take up the post of Clinical Lead)	10-15	0	0	0	0	10-15
Dr D Bush - GP Board Member	15-20	0	0	0	0	15-20
Dr M Kainth - GP Board Member	15-20	0	0	0	0	15-20
Dr R Rajcholan - GP Board Member	25-30	0	0	0	0	25-30
Dr J Parkes - GP Board Member (commenced in post 11/10/17)	5-10	0	0	0	0	5-10
Dr R Gulati - GP Board Member (commenced in post 11/10/17)	5-10	0	0	0	0	5-10
Dr M Asghar - GP Board Member (commenced in post 11/10/17)	5-10	0	0	0	0	5-10

J Oatridge – Acting Chair until 10/10/17, Lay Member after that date	45-50	0	0	0	0	45-50
P Roberts - Lay Member (left post 28/09/17)	0-5	0	0	0	0	0-5
P Price - Lay Member	10-15	0	0	0	0	10-15
L Trigg – Lay Member (commenced in post 11/04/17)	5-10	0	0	0	0	5-10
S McKie – Lay Member (commenced in post 01/11/17)	0-5	0	0	0	0	05
H Ryan - Board practice manager representative	5-10	0	0	0	0	5-10
A Chandock – Secondary Care Consultant (commenced in post 27/06/17)	5-10	0	0	0	0	5-10

\* This officer works across both Walsall and Wolverhampton CCGs and these figures represent the proportion payable by Wolverhampton CCG. The officer's full salary across both organisations was £93k.

\*\* This officer works across Dudley, Walsall and Wolverhampton CCGs and these figures represent the proportion payable by Wolverhampton CCG. The officer's full salary across all organisations was £120k.

# Estimate - in accordance with the CCG's policy for review of VSM pay the Remuneration Committee will consider and award the bonus relating to 2017-18 early in 2018-19.

GP Board Members are paid through the CCG's payroll provider with the relevant tax and NI deducted at source. Pension contributions are processed through NHS England via the GP SOLO process and therefore pension related benefits are not reported in the table above.

As lay members do not receive pensionable remuneration there are no entries in respect of pension related benefits for these members.



Dr Helen Hibbs  
Accountable Officer

21 May 2019

## **Staff report**

### **Staff consultation**

We are committed to encouraging an open and healthy dialogue with our 105 members of staff and have a number of mechanisms to meaningfully consult with staff:

- Staff Forum – bi-monthly meetings attended by CCG executive and staff representatives
- Representatives from across each function, HR and union representatives
- Joint Negotiating Consultative Committee (JNCC)
- Staff Briefing sessions held monthly
- Chief Officer Blog monthly
- Organisational Development Meetings
- Monthly Management Meetings
- Fortnightly Senior Management Team meetings
- Executive bulletins
- Monthly staff e-bulletin
- Regular e-mails
- Digital signage network – information displayed on strategically placed TV screens

The JNCC encourages effective communication with our staff through formal, quarterly meetings attended by CCG Executive management, HR and union representatives.

Staff Forum Meetings are held on a bi-monthly basis members discuss topics of interest, including national and local strategies, HR policies, employment legislation and local initiatives. The group also assesses the impact of these policies on the CCG and develops implementation plans where appropriate.

In the past year, the JNCC has completed work to review staff policies and the CCG's terms and conditions of employment. The CCG have also integrated to a full employee self-service (ESR) which enables CCG staff to record and collate timely and accurate information.

We have enhanced the internal communications screens which now include live RSS feeds from the CCG website, news agencies, weather and traffic reports. Content is updated daily with staff encouraged to contribute news from within their own areas. Information of new employees joining the CCG is also shared on the internal screens. Furthermore the CCG has adopted a new look Intranet which boasts increased functionality and a more user friendly layout.

The Executive team have arranged drop in sessions, walk arounds and monthly newsletters to support staff in understanding the on-going changes in the NHS at regional and national level.

A successful Away Day was held in July 2018 which included an external motivational presentation from Alastair Humphreys which was well received; the day also included presentations from each department which demonstrated their areas of work related to the previously developed CCG Values and importance within the wider CCG. The event was well received and another Away Day is planned for the same time in 2019.

The CCG's developments of the Organisational Values were further embedded within the organisation with the implementation of Values based Personnel Development Reviews (PDR's).

The CCG's 12 month rolling staff turnover rate is 0.84% up to 31<sup>st</sup> December 2018 and 12 month rolling sickness is 1.79% up to 31<sup>st</sup> December 2018 thanks to a proactive approach to managing and motivating staff.

We also encourage our providers to actively obtain and respond to feedback from their employees using the National Staff Survey or other local methods.

## **Equality**

WCCG published its Annual Equality report on 30 March 2019, along with its new Equality Objectives, demonstrating the CCG's commitment to Equality, Inclusion and Human Rights and meeting its legal duties.

The CCG has adopted a robust Equality Analysis and Due Regard approach to ensure that any decision it makes, affecting patients or staff, is analysed for its impact prior to the decision being made and due regard is then shown to the finding. The resulting findings, actions taken and mitigations are then evidenced through the CCG's Equality Analysis form and process – which is attached to each paper and decision. The tool allows potential and existing health inequalities to be explored and the impacts of the proposal on each of the nine protected groups covered by the Equality Act 2010 to be assessed.

The Equality Analysis process also takes into consideration human rights aspects when approving polices and making commissioning decisions.

### **Public sector equality duty**

The CCG Equality & Inclusion Annual Report sets out how the CCG has demonstrated 'due regard' to the public sector equality duty's three aims for 2018/19 and provided evidence for meeting the specific equality duty, which requires all public sector organisations to publish their equality information annually. The CCG's report for 2017/18 was published on 30 March 2019 and included the CCG's use of the NHS Equality Delivery system (EDS2) framework and template.

### **Monitoring of equality**

*Provider contracts* - The CCG is committed to gaining assurance around Equality, Inclusion and Human Rights from all the provider organisations for which the CCG is responsible. Key areas which the CCG has worked with the providers on have been: The NHS Workforce Race Equality Standard, the Accessible information Standard and compliance with the Public Sector Equality Duty. This has involved robust contract review and use of KPIs.

*Internally* - the CCG is committed to providing a diverse workforce which is reflective of the population served.

For continuing employment, training and career development of any disabled persons employed by the company, the CCG supports any member of staff that may need reasonable adjustments in order to be able to perform their current or future role. In line with the Equality Act, this can involve amendments to absence triggers for disabled employees and/or role adjustments to allow disabled staff to continue working. The CCG also offers a Flexible Working policy which

can be used to support staff with health issues on a temporary or permanent basis. The CCG also complies with the requirements of the Disability Confident Scheme.

Full and fair consideration to applications for employment within the CCG is covered by the CCG's Recruitment policy. Recruiting managers are required to shortlist using the specified essential and desirable criteria. Those shortlisted will then be asked role related questions determined by the requirements detailed within the role's person specification. Interview panels are recommended to consist of three members, they will ask all candidates the same basic questions, probing if required, and score the responses against the ideal answers. The scores are totaled to identify the preferred candidate. At least one member of the recruiting panel will have completed the Recruitment and Selection training.

We have identified key equality objectives and aligned these to the Equality Delivery System 2 (EDS2). During 2019 these will both be reviewed and further updates published.

Further detail including the relevant reports can be found on the CCG's Equality page:

<https://wolverhamptonccg.nhs.uk/about-us/equality-inclusion-and-human-rights-2018-19>

## **Sustainable development – environmental impact**

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of by making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. We work closely with our accommodation partner Wolverhampton University to ensure our largest environmental impact (accommodation) is minimised. The University has a robust sustainability strategy and is committed to a 40% reduction in Carbon emissions by 2020 and is engaging on a range of initiatives to achieve this including voltage optimisation, piloting the use of a combined heat and power plant and LED light replacement. We encourage all our staff to work in partnership with the University and we are committed to working with them in the future to reduce our carbon footprint even further.

## Consultancy expenditure

The CCG spent £72k in 2018/19 on consultancy which is included within the gross operating costs note to the accounts (Note 5). The main expenditure within this was:

- Johnston Associates Ltd (£36k), primary care estates development management;
- The Design Buro (£7k), architectural services on Bilston Health Centre
- The Consultation Institute (£27k), architectural services on Bilston Health Centre

## Staff costs (audited)

2018-19	Admin			Programme			Total		
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits									
Salaries and wages	2,535	144	2,680	1,538	365	1,903	4,074	509	4,583
Social security costs	280	0	280	148	0	148	428	0	428
Employer contributions to the NHS Pension Scheme	324	0	324	162	0	162	487	0	487
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy	7	0	7	0	0	0	7	0	7
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
<b>Gross employee benefits expenditure</b>	<b>3,147</b>	<b>144</b>	<b>3,291</b>	<b>1,849</b>	<b>365</b>	<b>2,214</b>	<b>4,996</b>	<b>509</b>	<b>5,505</b>
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
<b>Total - Net admin employee benefits including capitalised costs</b>	<b>3,147</b>	<b>144</b>	<b>3,291</b>	<b>1,849</b>	<b>365</b>	<b>2,214</b>	<b>4,996</b>	<b>509</b>	<b>5,505</b>
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
<b>Net employee benefits excluding capitalised costs</b>	<b>3,147</b>	<b>144</b>	<b>3,291</b>	<b>1,849</b>	<b>365</b>	<b>2,214</b>	<b>4,996</b>	<b>509</b>	<b>5,505</b>

2017-18	Admin			Programme			Total		
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
<b>Employee Benefits</b>									
Salaries and wages	2,359	108	2,467	1,297	456	1,753	3,656	565	4,220
Social security costs	260	0	260	127	0	127	387	0	387
Employer contributions to the NHS									
Pension Scheme	304	0	304	137	0	137	441	0	441
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy	4	0	7	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
<b>Gross employee benefits expenditure</b>	<b>2,927</b>	<b>108</b>	<b>3,032</b>	<b>1,561</b>	<b>456</b>	<b>2,017</b>	<b>4,484</b>	<b>565</b>	<b>5,049</b>
<b>Less recoveries in respect of employee benefits (note 4.1.2)</b>									
	0	0	0	0	0	0	0	0	0
<b>Total - Net admin employee benefits including capitalised costs</b>	<b>2,927</b>	<b>108</b>	<b>3,032</b>	<b>1,561</b>	<b>456</b>	<b>2,017</b>	<b>4,484</b>	<b>565</b>	<b>5,049</b>
<b>Less Employee costs capitalised</b>									
<b>Net employee benefits excluding capitalised costs</b>	<b>2,927</b>	<b>108</b>	<b>3,032</b>	<b>1,561</b>	<b>456</b>	<b>2,017</b>	<b>4,484</b>	<b>565</b>	<b>5,049</b>

A summarised version of this information can be found within Notes 4.1.1 & 4.1.2 in the Annual Accounts.

The CCG staff fall into the staff groupings Medical and Dental, Nursing and Midwifery, Scientific and Technical as well as Administration and Clerical. The majority of the staff are Administration and Clerical.

### Trade Union Facility Time

WCCG supports staff to carry out their trade union duties as per *The Trade Union (Facility Time Publication Requirements) Regulations 2017*. For the period 18/19 WCCG had no paid trade union activities hours (18 hours in 17/18).

## Staff analysis by gender (audited)

Staff Grouping	Female	Male	Total
Governing Body	7	11	18
Other Senior Management (Band 8C+)	10	4	14
All Other employees	82	21	103
<b>Grand Total</b>	<b>99</b>	<b>36</b>	<b>135</b>

\*Note: Headcount as at March 2019

## Pension liabilities

Details of how pension liabilities are treated in the accounts of the CCG can be found under note 4.5 (page 99) of the annual accounts.

Pension calculations relating to senior managers can be found within the Remuneration Report.

## Sickness absence data

Figures Converted by DH to Best Estimates of Required Data Items	Statistics Published by NHS Digital from electronic staff record data warehouse			
Average full-time equivalent (FTE) 2018 calendar year	Adjusted FTE days lost to Cabinet Office definitions 2018 calendar year	FTE-Days Available	FTE-Days recorded Sickness Absence	Average Sick Days per FTE
93	372	33,939	604	4

As per note 4.3 of the CCG's annual accounts, the average number of staff sick days lost per full-time equivalent (FTE) in 2018 was 4.0 (6.7 in 2017).

## Health and safety

Our Health and Safety Management Plan has been reviewed to actively safeguard our staff and visitors. We have a variety of arrangements in place that enable us to maintain low incident rates. When problems are identified, we work with teams to address and resolve those issues through the reporting process.

Our Quality and Safety Committee and Senior Management Team oversee this arrangement. This year we have identified a new provider for our health and safety offer and have identified named local colleagues to support implementation of the offer.

Our plan includes:

- Workplace inspections will be undertaken at quarterly intervals to ensure safety standards are being maintained and where issues have been identified they will be acted upon
- Implementation of the CCG's Health and Safety Risk Assessment.
- Working environment assessments.
- Health and Wellbeing of staff remains engrained as part of the organisations Health and Wellbeing agenda, which promotes healthy eating and lifestyles. This has full engagement through the CCG's Staff Forum.

The CCG's Stress and Wellbeing Policy has been embedded within the organisation and is fully available to staff on the CCG's intranet.

As an organisation we have supported our pregnant workers throughout their pregnancy and return to work, to ensure they have a suitable and sufficient assessment of risk to safeguard themselves and their unborn child from harm whilst at work.

The Health and Safety Management Plan will be available for staff to access on the CCG's intranet, and will be supported by an end-of-year report to the CCG's Quality & Safety Committee.

### **Health and wellbeing update**

In line with the work of the CCG's Staff Forum, overseen by the Corporate Operations Manager there are a range of health & wellbeing activities that continue to take place in line with the Wellbeing Program of Work including:-

- Flu vaccinations took place throughout Quarter 3.
- The new values based PDRs have been implemented and all staff have had a review during the year.
- Staff Survey findings have been very positive with 95% of staff feeling supported at work.
- Whole CCG and separate departmental Away Days are held which are used to reflect and develop as an organisation.
- The CCG is investing in resilience training and support for staff as the NHS goes through another period of change and we move towards a single commissioner voice for the Black Country.
- Charitable events and fundraising continue to take place within teams
- Fresh fruit continues to be provided each month

### **Fraud**

CCG staff have access to risk specialists employed in functions such as health and safety, infection control, information governance and internal audit/counter fraud. Staff also have access to the communications shared by the Local Counter Fraud Specialist on the CCG's intranet page, which contains policies and guidance relating to reporting concerns about fraudulent behaviour.

The CCG has a whistle blowing policy that also encourages staff to report fraudulent activity to the Local Counter Fraud Specialist.

The Audit and Governance Committee approves the CCG's counter fraud work plan on an annual basis and monitors progress on the implementation of counter fraud activities at each of its meetings.

## Off-payroll engagements

Off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months are as follows:

	Number
Total number of existing engagements as of 31 March 2019	1
<b><i>Of which, the number that have existed:</i></b>	
• For less than one year at the time of reporting	
• For between one and two years at the time of reporting	
• For between two and three years at the time of reporting	1
• For between three and four years at the time of reporting	
• For four or more years at the time of reporting	

All existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and March 2019, for more than £245 per day and that last for longer than six months:

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	1
<b><i>Of which:</i></b>	
No. assessed as caught by IR35	
No. assessed as not caught by IR35	1
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	
No. of engagements reassessed for consistency / assurance purposes during the year	1

No. of engagements that saw a change to IR35 status following the consistency review	
--	--

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019:

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure must include both on payroll and off-payroll engagements.	19

## Exit packages and severance pay

The CCG has made no payments in respect of exit packages in 2018/19, (nil in 2017/18).

## Customer care

Our complaints procedures reflect the Parliamentary and Health Service Ombudsman's six principles for remedy:

- getting it right
- being customer focused
- being open and accountable
- acting fairly and proportionately
- putting things right
- seeking continuous improvement

The views and opinions of the patients we commission services for are vital in helping us deliver the best healthcare to our communities. We are committed to providing accessible, equitable and effective services and welcome views about services we provide and are responsible for commissioning. We actively encourage feedback through public participation groups, and routinely monitor patient experience feedback with service providers in joint engagement meetings and through systems such as Quality Matters.

We place a high priority on the handling of complaints and we recognise that suggestions, constructive criticisms and complaints can be valuable aids to improving services and informing service redesign.

We are confident that we have a clear complaints policy that signposts the public to the correct points of contact when the CCG are not the provider of care for a complaint.

The CCG's Quality team handles all customer care enquiries, MP requests and Ombudsman investigations that are directed to the CCG. The team also deals with all formal complaints relating to CCG service responsibility and points other enquiries to commissioned providers in the first instance or where complaints are Primary Care related these are still being handled nationally by NHS England.

## **Emergency preparedness**

Emergency planning and resilience and response (EPRR), is a statutory function under the Civil Contingencies Act (CCA) 2004. All NHS organisations and healthcare providers are required to have plans and processes in place for responding effectively to a major incident.

WCCG is a Category Two responder as defined by the CCA 2004. This means that the CCG is part of the response to any emergency affecting the population, in partnership with its commissioned services, NHS England, the local authority, Public Health England, the emergency services and other health bodies.

In Wolverhampton we work to continually plan for all eventualities on a West Midlands wide footprint. In the last year this included working with providers and NHS England to ensure reassurance in the future for the public. With the increased scrutiny around Brexit, Wolverhampton CCG is adopting a City wide approach with its providers to ensure all aspects including Medicines, Vaccines, Consumables and Data protection are all addressed pro-actively and concisely.

We have also continued to develop our emergency preparedness, business continuity plans and maintain a close working relationship with partners, including our Category 1 responders in Wolverhampton, to ensure a capability to respond to any incident or emergency. We continue to train our Executive team and staff to help them be prepared in the event of any future incidents. We will build on this by arranging live table top exercises in 2018 that will test the resilience of WCCG's EPRR programme of work.

The CCG completes an annual self-assessment against EPRR core standards, participates in local and regional training, and continues to develop and improve its business continuity arrangements exploring mutual aid arrangements with other CCGs locally. The CCG was rated as 'Substantially Compliant' following our annual submission to NHS England.

Further assurance and more detailed information regarding the requirements specified for NHS providers can be found within the standard NHS contract, section SC30 Emergency Preparedness and Resilience Including Major Incidents.

A senior managers/executives rota system is in place across the Black Country to deal with issues that arise out of hours. To support senior managers/executives on call, technology is being developed to streamline the recording of information that will provide a robust evidence trail and ensure a structured approach to the transition between in-hours and out-of-hours.

## **Payments and charges**

### **Better Payments Practice (prompt payment) Code**

The CCG is an approved signatory to the prompt payment code. The code sets standards for payment practice and best practice. Signatories agree to pay suppliers on time, give clear guidance to suppliers, and encourage the adoption of the code through supply chains. This means suppliers can have confidence in the CCG paying bills in line with the code.

Details of the CCG's compliance with the code are given in Note 6 of the accounts.

### **Cost Allocation & Setting of Charges for Information**

We certify that the clinical commissioning group has complied with the Treasury's guidance on cost allocation and the setting of charges for information.

### **External Auditor's Remuneration**

The CCG's external auditor is Grant Thornton UK LLP. Work performed for the CCG in 2018/19 related solely to the statutory audit and amounted to £50,160, (£50,160 in 17/18).

This is shown within Audit Fees in Note 5 of the annual accounts.

### **Parliamentary Accountability and Audit Report**

WCCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at Notes 1, 1 and 5 respectively. An audit certificate and report are also included in this Annual Report at p114.



Dr Helen Hibbs  
Accountable Officer

21 May 2019

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Data entered below will be used throughout the workbook:

Entity name:	NHS Wolverhampton CCG
This year	2018-19
Last year	2017-18
This year ended	31-March-2019
Last year ended	31-March-2018
This year commencing:	01-April-2018
Last year commencing:	01-April-2017

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**Statement of Comprehensive Net Expenditure for the year ended  
31 March 2019**

	Note	2018-19 £'000	2017-18 £'000
Income from sale of goods and services	2	-	-
Other operating income	2	(677)	(1,895)
<b>Total operating income</b>		<b>(677)</b>	<b>(1,895)</b>
Staff costs	4	5,505	5,053
Purchase of goods and services	5	408,659	390,700
Depreciation and impairment charges	5	-	-
Provision expense	5	218	(27)
Other Operating Expenditure	5	303	399
<b>Total operating expenditure</b>		<b>414,685</b>	<b>396,125</b>
<b>Net Operating Expenditure</b>		<b>414,008</b>	<b>394,230</b>
Finance income		-	-
Finance expense		-	-
<b>Net expenditure for the year</b>		<b>414,008</b>	<b>394,230</b>
Net (Gain)/Loss on Transfer by Absorption		-	-
<b>Total Net Expenditure for the Financial Year</b>		<b>414,008</b>	<b>394,230</b>
<b>Other Comprehensive Expenditure</b>			
<b><u>Items which will not be reclassified to net operating costs</u></b>			
Net (gain)/loss on revaluation of PPE		-	-
Net (gain)/loss on revaluation of Intangibles		-	-
Net (gain)/loss on revaluation of Financial Assets		-	-
Actuarial (gain)/loss in pension schemes		-	-
Impairments and reversals taken to Revaluation Reserve		-	-
<b><u>Items that may be reclassified to Net Operating Costs</u></b>			
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
<b>Sub total</b>		<b>-</b>	<b>-</b>
<b>Comprehensive Expenditure for the year ended 31 March 2019</b>		<b>414,008</b>	<b>394,230</b>

**Statement of Financial Position as at  
31 March 2019**

		2018-19	2017-18
	Note	£'000	£'000
<b>Non-current assets:</b>			
Property, plant and equipment	13	-	-
Intangible assets	14	-	-
Investment property	15	-	-
Trade and other receivables	17	-	-
Other financial assets	18	-	-
<b>Total non-current assets</b>		<u>-</u>	<u>-</u>
<b>Current assets:</b>			
Inventories	16	-	-
Trade and other receivables	17	4,785	3,582
Other financial assets	18	-	-
Other current assets	19	-	-
Cash and cash equivalents	20	67	85
<b>Total current assets</b>		<b>4,852</b>	3,667
Non-current assets held for sale	21	-	-
<b>Total current assets</b>		<b>4,852</b>	3,667
<b>Total assets</b>		<b>4,852</b>	3,667
<b>Current liabilities</b>			
Trade and other payables	23	(42,337)	(35,758)
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	(398)	(227)
<b>Total current liabilities</b>		<b>(42,735)</b>	(35,985)
<b>Non-Current Assets plus/less Net Current Assets/Liabilities</b>		<b>(37,883)</b>	(32,318)
<b>Non-current liabilities</b>			
Trade and other payables	23	-	-
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	-	-
<b>Total non-current liabilities</b>		<b>-</b>	<b>-</b>
<b>Assets less Liabilities</b>		<b>(37,883)</b>	(32,318)
<b>Financed by Taxpayers' Equity</b>			
General fund		(37,883)	(32,318)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
<b>Total taxpayers' equity:</b>		<b>(37,883)</b>	(32,318)

The notes on pages 96 to 113 form part of this statement

The financial statements on pages 86 to 113 were approved by the Governing Body on 21st May 2019 and signed on its behalf by:



Dr Helen Hibbs  
Accountable Officer

21 May 2019

**31 March 2019**

	<b>General fund £'000</b>	<b>Revaluation reserve £'000</b>	<b>Other reserves £'000</b>	<b>Total reserves £'000</b>
<b>Changes in taxpayers' equity for 2018-19</b>				
<b>Balance at 01 April 2018</b>	(32,318)	0	0	(32,318)
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	0
Impact of applying IFRS 9 to Opening Balances	0	0	0	0
Impact of applying IFRS 15 to Opening Balances	0	0	0	0
<b>Adjusted NHS Clinical Commissioning Group balance at 31 March 2019</b>	<b>(32,318)</b>	<b>0</b>	<b>0</b>	<b>(32,318)</b>
<b>Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19</b>				
Net operating expenditure for the financial year	(414,008)	0	0	(414,008)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
<b>Total valuations against revaluation reserve</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
<b>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</b>	<b>(414,008)</b>	<b>0</b>	<b>0</b>	<b>(414,008)</b>
Net funding	408,443	0	0	408,443
<b>Balance at 31 March 2019</b>	<b>(37,883)</b>	<b>0</b>	<b>0</b>	<b>(37,883)</b>
<b>Changes in taxpayers' equity for 2017-18</b>				
<b>Balance at 01 April 2017</b>	(20,682)	0	0	(20,682)
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	0
<b>Adjusted NHS Clinical Commissioning Group balance at 31 March 2018</b>	<b>(20,682)</b>	<b>0</b>	<b>0</b>	<b>(20,682)</b>
<b>Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18</b>				
Net operating costs for the financial year	(394,230)			(394,230)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
<b>Total valuations against revaluation reserve</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
<b>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</b>	<b>(394,230)</b>	<b>0</b>	<b>0</b>	<b>(394,230)</b>
Net funding	382,594	0	0	382,594
<b>Balance at 31 March 2018</b>	<b>(32,318)</b>	<b>0</b>	<b>0</b>	<b>(32,318)</b>

The notes on pages 96 to 113 form part of this statement

**Statement of Cash Flows for the year ended  
31 March 2019**

	<b>2018-19 £'000</b>	<b>2017-18 £'000</b>
<b>Cash Flows from Operating Activities</b>		
Net operating expenditure for the financial year	(414,008)	(394,230)
Depreciation and amortisation	0	0
Impairments and reversals	0	0
Non-cash movements arising on application of new accounting standards	0	0
Movement due to transfer by Modified Absorption	0	0
Other gains (losses) on foreign exchange	0	0
Donated assets received credited to revenue but non-cash	0	0
Government granted assets received credited to revenue but non-cash	0	0
Interest paid	0	0
Release of PFI deferred credit	0	0
Other Gains & Losses	0	0
Finance Costs	0	0
Unwinding of Discounts	0	0
(Increase)/decrease in inventories	0	0
(Increase)/decrease in trade & other receivables	(1,203)	(320)
(Increase)/decrease in other current assets	0	0
Increase/(decrease) in trade & other payables	6,579	12,077
Increase/(decrease) in other current liabilities	0	0
Provisions utilised	(47)	(41)
Increase/(decrease) in provisions	218	(27)
<b>Net Cash Inflow (Outflow) from Operating Activities</b>	<b>(408,461)</b>	<b>(382,541)</b>
<b>Cash Flows from Investing Activities</b>		
Interest received	0	0
(Payments) for property, plant and equipment	0	0
(Payments) for intangible assets	0	0
(Payments) for investments with the Department of Health	0	0
(Payments) for other financial assets	0	0
(Payments) for financial assets (LIFT)	0	0
Proceeds from disposal of assets held for sale: property, plant and equipment	0	0
Proceeds from disposal of assets held for sale: intangible assets	0	0
Proceeds from disposal of investments with the Department of Health	0	0
Proceeds from disposal of other financial assets	0	0
Proceeds from disposal of financial assets (LIFT)	0	0
Non-cash movements arising on application of new accounting standards	0	0
Loans made in respect of LIFT	0	0
Loans repaid in respect of LIFT	0	0
Rental revenue	0	0
<b>Net Cash Inflow (Outflow) from Investing Activities</b>	<b>0</b>	<b>0</b>
<b>Net Cash Inflow (Outflow) before Financing</b>	<b>(408,461)</b>	<b>(382,541)</b>
<b>Cash Flows from Financing Activities</b>		
Grant in Aid Funding Received	408,443	382,594
Other loans received	0	0
Other loans repaid	0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT	0	0
Capital grants and other capital receipts	0	0
Capital receipts surrendered	0	0
Non-cash movements arising on application of new accounting standards	0	0
<b>Net Cash Inflow (Outflow) from Financing Activities</b>	<b>408,443</b>	<b>382,594</b>
<b>Net Increase (Decrease) in Cash &amp; Cash Equivalents</b>	<b>(18)</b>	<b>53</b>
<b>Cash &amp; Cash Equivalents at the Beginning of the Financial Year</b>	<b>85</b>	<b>32</b>
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies	0	0
<b>Cash &amp; Cash Equivalents (including bank overdrafts) at the End of the Financial Year</b>	<b>67</b>	<b>85</b>

The notes on pages 96 to 113 form part of this statement

**Notes to the financial statements**

**1 Accounting Policies**

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

**1.1 Going Concern**

These accounts have been prepared on a going concern basis.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

NHS Wolverhampton CCG meets the requirements noted above and further to this:

- the CCG achieved a cumulative surplus of £10.028m, (in-year surplus of £42k), which was in line with the target set by NHS England (see note 40 of the accounts);
- the CCG has an agreed plan with NHS England for 2019/20 with a target cumulative surplus of £10m;
- the CCG's working balances remain constant and cash is managed effectively.

On this basis, NHS Wolverhampton CCG considers itself to be a going concern.

**1.2 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.

**1.3 Movement of Assets within the Department of Health and Social Care Group**

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

**1.4 Pooled Budgets**

The clinical commissioning group entered into a pooled budget arrangement with Wolverhampton City Council on 1st April 2015 under a section 75 (NHS Act 2006) partnership agreement. This was for the purpose of commissioning health and social care services under the Better Care Fund (BCF). The Host Partner is Wolverhampton City Council.

The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

**1.5 Critical Accounting Judgements & Key Sources of Estimation Uncertainty**

In the application of the clinical commissioning group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

**Notes to the financial statements**

**1.5.1 Critical Judgements in Applying Accounting Policies**

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- *Better Care Fund*

The clinical commissioning group's management has made a critical judgement in relation to applying accounting policies to the Better Care Fund (BCF). This relates to the arrangements described in the section 75 agreement it has with the City of Wolverhampton Council. The substance of each programme that forms part of the BCF Pooled Budget has been assessed as to whether it meets the principles within IFRS 11: 'Joint Arrangements'. Specific programmes have been assessed as either: (1) Joint Commissioning arrangements under which each Pool Partner accounts for their share of expenditure and balances with the end provider; (2) Lead Commissioning arrangements under which the lead commissioner accounts for expenditure with the end provider and other partners report transactions and balances with the lead commissioner; or (3) Sole Control arrangements under which the provisions of IFRS 11 do not apply. The Fund has been considered a Joint Operation with Lead Commissioning arrangements.

**1.5.2 Key Sources of Estimation Uncertainty**

The following are the key estimations that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- *Provisions*

When estimating provisions the clinical commissioning group uses estimates based on expert advice from solicitors, other external agents and the experience of its managers.

- *Prescribing Costs*

The Clinical Commissioning Group recognises the cost of drug prescribing based on data received from the NHS Prescription Pricing Authority (PPA). Reports are received on a monthly basis, but reflect transactions up to the end of February only. March costs are estimated using historical levels of expenditure.

**1.6 Revenue**

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

**1.70 Employee Benefits**

**1.7.1 Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave 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.

**1.7.2 Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

**1.8 Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenses and liabilities in respect of grants are recognised when the clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

**1.9 Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee, however, the clinical commissioning group had no finance leases. All other leases are classified as operating leases.

**1.9.1 The Clinical Commissioning Group as Lessee**

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

**Notes to the financial statements**

**1.10 Cash & 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 clinical commissioning group's cash management.

**1.11 Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.29% (2017-18: positive 0.10%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of 0.76% (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 1.14% (2017-18: negative 1.85% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

All 2018-19 percentages are expressed in nominal terms with 2017-18 being the last financial year that HM Treasury provided real general provision discount rates.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

**1.12 Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with clinical commissioning group.

**1.13 Non-clinical Risk Pooling**

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the 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 as and when they become due.

**1.14 Continuing Healthcare Risk Pooling**

In 2014-15 a risk pool scheme was introduced by NHS England for continuing healthcare claims for claim periods prior to 31 March 2013. Under the scheme the clinical commissioning group contributed annually to a pooled fund, which was used to settle the claims until 2016/17. From April 2017 NHS England have identified a central reserve to cover the payments, including those relating to appeals and the clinical commissioning group is no longer required to make a contribution.

**1.15 Carbon Reduction Commitment Scheme**

The CCG Does not have a Carbon Reduction Scheme

**1.16 Contingent liabilities and contingent assets**

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

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

**Notes to the financial statements**

**1.17 Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- . Financial assets at amortised cost;
- . Financial assets at fair value through other comprehensive income and ;
- . Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

**1.17.1 Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments.

After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

**1.17.2 Financial assets at fair value through other comprehensive income**

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

In 2018/19 the clinical commissioning group did not hold any financial assets at fair value through other comprehensive income.

**1.17.3 Financial assets at fair value through profit and loss**

Financial assets measured at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

In 2018/19 the clinical commissioning group did not hold any financial assets at fair value through profit and loss.

**1.17.4 Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation.

The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally DHSC provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

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 the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

**Notes to the financial statements**

**1.18 Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

**1.18.1 Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

In 2018/19 the clinical commissioning group did not hold any financial guarantee contracts.

**1.18.2 Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

In 2018/19 the clinical commissioning group did not hold any financial liabilities at fair value through profit and loss.

**1.18.3 Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Financial liabilities in respect of partially completed contracts for patient services are accrued at the statement of financial position date with movements being recorded within gross operating costs in the year they occur.

**1.19 Value Added Tax**

Most of the activities of the clinical commissioning group 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.

**1.20 Third Party Assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

**1.21 Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

**1.22 Joint Operations**

Joint operations are activities undertaken by the clinical commissioning group in conjunction with one or more other parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

**1.23 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

**2 Other Operating Revenue**

	2018-19 Total	2017-18 Total
	£'000	£'000
<b>Income from sale of goods and services (contracts)</b>		
Education, training and research	-	-
Non-patient care services to other bodies	-	-
Patient transport services	-	-
Prescription fees and charges	-	-
Dental fees and charges	-	-
Income generation	-	-
Other Contract income	-	-
Recoveries in respect of employee benefits	-	-
<b>Total Income from sale of goods and services</b>	<u><u>-</u></u>	<u><u>-</u></u>
<b>Other operating income</b>		
Rental revenue from finance leases	-	-
Rental revenue from operating leases	-	-
Charitable and other contributions to revenue expenditure: NHS	-	-
Charitable and other contributions to revenue expenditure: non-NHS	71	71
Receipt of donations (capital/cash)	-	-
Receipt of Government grants for capital acquisitions	-	-
Continuing Health Care risk pool contributions	-	-
Non cash apprenticeship training grants revenue	6	-
Other non contract revenue	600	1,824
<b>Total Other operating income</b>	<u><u>677</u></u>	<u><u>1,895</u></u>
<b>Total Operating Income</b>	<u><u>677</u></u>	<u><u>1,895</u></u>

Programme revenue is revenue received for activities for which the sole or primary purpose is to improve the quality of health services

Admin revenue is revenue received that is not directly attributable to the provision of healthcare services.

Revenue in this note does not include cash received from NHS England.

**3 Revenue**

The clinical commissioning group receives no revenue from the sale of goods and services.

#### 4. Employee benefits and staff numbers

##### 4.1.1 Employee benefits 2018-19

	Permanent Employees £'000	Other £'000	Total £'000
<b>Employee Benefits</b>			
Salaries and wages	4,074	509	4,583
Social security costs	428	0	428
Employer Contributions to NHS Pension scheme	487	0	487
Other pension costs	0	0	0
Apprenticeship Levy	7	0	7
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
<b>Gross employee benefits expenditure</b>	<b>4,996</b>	<b>509</b>	<b>5,505</b>
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
<b>Total - Net admin employee benefits including capitalised costs</b>	<b>4,996</b>	<b>509</b>	<b>5,505</b>
Less: Employee costs capitalised	0	0	0
<b>Net employee benefits excluding capitalised costs</b>	<b>4,996</b>	<b>509</b>	<b>5,505</b>

##### 4.1.1 Employee benefits 2017-18

	Permanent Employees £'000	Other £'000	Total £'000
<b>Employee Benefits</b>			
Salaries and wages	3,656	565	4,220
Social security costs	387	0	387
Employer Contributions to NHS Pension scheme	441	0	441
Other pension costs	0	0	0
Apprenticeship Levy	4	0	4
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
<b>Gross employee benefits expenditure</b>	<b>4,488</b>	<b>565</b>	<b>5,053</b>
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
<b>Total - Net admin employee benefits including capitalised costs</b>	<b>4,488</b>	<b>565</b>	<b>5,053</b>
Less: Employee costs capitalised	0	0	0
<b>Net employee benefits excluding capitalised costs</b>	<b>4,488</b>	<b>565</b>	<b>5,053</b>

##### 4.1.2 Recoveries in respect of employee benefits

	Permanent Employees £'000	Other £'000	2018-19 Total £'000	2017-18 Total £'000
<b>Employee Benefits - Revenue</b>				
Salaries and wages	-	-	-	-
Social security costs	-	-	-	-
Employer contributions to the NHS Pension Scheme	-	-	-	-
Other pension costs	-	-	-	-
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
<b>Total recoveries in respect of employee benefits</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>

Further details regarding staff costs are contained within the Remuneration Report of the Annual Report.

**4.2 Average number of people employed**

	2018-19			2017-18		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
<b>Total</b>	<b>95.52</b>	<b>6.50</b>	<b>102.02</b>	<b>85.00</b>	<b>6.00</b>	<b>91.00</b>
Of the above:						
Number of whole time equivalent people engaged on capital projects	0	0	0	0	0	0

**4.3. Staff sickness absence and ill health retirements**

	2018-19 Number	2017-18 Number
Total Days Lost	372	583
Total Staff Years	93	86
Average working Days Lost	<u>4</u>	<u>7</u>
Number of persons retired early on ill health grounds	0	0
Total additional Pensions liabilities accrued in the year	£'000 0	£'000 0

*Ill health retirement costs are met by the NHS Pension Scheme*

**4.4. Exit packages agreed in the financial year**

The CCG has made no payments in respect of exit packages (nil in 2017-18).

The CCG has made no special payments in respect of employee departures (nil in 2017-18).

#### **4.5 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](http://www.nhsbsa.nhs.uk/pensions). Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

##### **4.5.1 Accounting valuation**

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

##### **4.5.2 Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

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

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

For 2018-19, employers' contributions of £486,579 were payable to the NHS Pensions Scheme (2017-18: £441,456) at the rate of 14.38% of pensionable pay. These costs are included in the NHS pension line of note 4.1.1.

**5. Operating expenses**

	2018-19 Total £'000	2017-18 Total £'000
<b>Purchase of goods and services</b>		
Services from other CCGs and NHS England	2,189	2,349
Services from foundation trusts	53,813	51,966
Services from other NHS trusts	211,189	201,124
Provider Sustainability Fund (Sustainability Transformation Fund 1718)	-	-
Services from Other WGA bodies	1	-
Purchase of healthcare from non-NHS bodies	42,787	38,840
Purchase of social care	8,750	2
General Dental services and personal dental services	-	-
Prescribing costs	45,356	47,097
Pharmaceutical services	-	-
General Ophthalmic services	342	325
GPMS/APMS and PCTMS	36,913	34,986
Supplies and services – clinical	1,357	1,354
Supplies and services – general	1,264	9,941
Consultancy services	72	99
Establishment	2,537	1,401
Transport	7	12
Premises	1,155	829
Audit fees	50	50
Other non statutory audit expenditure		
Internal audit services	77	73
Other services	1	-
Other professional fees	382	23
Legal fees	61	58
Education, training and conferences	353	170
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
<b>Total Purchase of goods and services</b>	<b>408,659</b>	<b>390,700</b>
<b>Depreciation and impairment charges</b>		
Depreciation	-	-
Amortisation	-	-
Impairments and reversals of property, plant and equipment	-	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets		
Assets carried at amortised cost	-	-
Assets carried at cost	-	-
Available for sale financial assets	-	-
Impairments and reversals of non-current assets held for sale	-	-
Impairments and reversals of investment properties	-	-
<b>Total Depreciation and impairment charges</b>	<b>-</b>	<b>-</b>
<b>Provision expense</b>		
Change in discount rate	-	-
Provisions	218	(27)
<b>Total Provision expense</b>	<b>218</b>	<b>(27)</b>
<b>Other Operating Expenditure</b>		
Chair and Non Executive Members	281	261
Grants to Other bodies	-	-
Clinical negligence	3	1
Research and development (excluding staff costs)	14	20
Expected credit loss on receivables	-	7
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	-	-
Non cash apprenticeship training grants	6	-
Other expenditure	-	110
<b>Total Other Operating Expenditure</b>	<b>303</b>	<b>399</b>
<b>Total operating expenditure</b>	<b>409,180</b>	<b>391,072</b>

Expenditure includes £39m in relation to services commissioned under Better Care Fund pooled budget arrangements.  
Note 35 provides further detail regarding this pooled budget.

The liability in respect of partially completed patient spells is included within the statement of financial position with annual movements being charged to gross operating costs. The movement in 2018/19 was an increase of £460k which is reflected within services from foundation trust & other NHS trusts in the gross operating costs shown above.

In addition a prepayment is included within the statement of financial position in relation to maternity services, with the corresponding credit movement included within services from other NHS trusts in the gross operating costs shown above. This is to recognise that an upfront block payment is made for maternity pathways which include all episodes of care from first ante-natal appointment to delivery. The movement in 2018/19 was an increase in the prepayment of £86k.

The CCG's contract with its external auditor provides for a limitation of the auditor's liability. The principal terms of this limitation are:

- the total aggregate liability of each Party to the other Party for each year of the Contract shall be subject to a limit of £2 million for all defaults resulting in direct loss or damage to the property of the other party, and;
- in respect of all other defaults, claims, losses or damages whether arising from breach of contract, misrepresentation (whether tortious or statutory), tort (including negligence), breach of statutory duty or otherwise shall in no event exceed the greater of the sum of £2 million or a sum equivalent to 125% of the annual Contract Charges.

#### **6.1 Better Payment Practice Code**

<b>Measure of compliance</b>	<b>2018-19 Number</b>	<b>2018-19 £'000</b>	<b>2017-18 Number</b>	<b>2017-18 £'000</b>
<b>Non-NHS Payables</b>				
Total Non-NHS Trade invoices paid in the Year	9,455	127,607	8,710	120,160
Total Non-NHS Trade Invoices paid within target	9,253	126,495	8,501	118,902
<b>Percentage of Non-NHS Trade invoices paid within target</b>	<b>97.9%</b>	<b>99.1%</b>	97.6%	99.0%
<b>NHS Payables</b>				
Total NHS Trade Invoices Paid in the Year	3,721	273,909	3,618	255,987
Total NHS Trade Invoices Paid within target	3,679	273,037	3,598	255,505
<b>Percentage of NHS Trade Invoices paid within target</b>	<b>98.9%</b>	<b>99.7%</b>	99.4%	99.8%

#### **6.2 The Late Payment of Commercial Debts (Interest) Act 1998**

<b>2018-19 £'000</b>	<b>2017-18 £'000</b>
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Amounts included in finance costs from claims made under this legislation	-
Compensation paid to cover debt recovery costs under this legislation	-
<b>Total</b>	<b>-</b>

#### **7 Income Generation Activities**

The clinical commissioning group had no Income Generation activities(none in 2017-18).

#### **8. Investment revenue**

The clinical commissioning group had no Investment revenue(none in 2017-18).

#### **9. Other gains and losses**

The clinical commissioning group had no other gains and losses (none in 2017-18).

#### **10.1 Finance costs**

The clinical commissioning group had no Finance costs(none in 2017-18).

#### **11. Net gain/(loss) on transfer by absorption**

The clinical commissioning group had no Net gain/loss on transfer by absorption(none in 2017-18).

## 12. Operating Leases

### 12.1 As lessee

#### 12.1.1 Payments recognised as an Expense

	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
<b>Payments recognised as an expense</b>								
Minimum lease payments	-	712	8	720	-	674	6	680
Contingent rents	-	-	-	-	-	-	-	-
Sub-lease payments	-	-	-	-	-	-	-	-
<b>Total</b>	<b>-</b>	<b>712</b>	<b>8</b>	<b>720</b>	<b>-</b>	<b>674</b>	<b>6</b>	<b>680</b>

The clinical commissioning group held an operating lease with University of Wolverhampton Science Park Limited for the rental of office accommodation at a cost of £106k in 2018/19, (£98k in 2017/18).

Minimum lease payments in respect of buildings also include void and subsidy charges of £425k (£408k in 2017-18) from NHS Property Services Limited and £182k (£168k in 2017-18) from Community Health Partnerships.

Other leases of £8k relate to leases held with Canon UK for the rental of photocopiers, (£6k in 2017/18).

#### 12.1.2 Future minimum lease payments

	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
<b>Payable:</b>								
No later than one year	-	26	-	26	-	40	4	44
Between one and five years	-	-	-	-	-	-	-	-
After five years	-	-	-	-	-	-	-	-
<b>Total</b>	<b>-</b>	<b>26</b>	<b>-</b>	<b>26</b>	<b>-</b>	<b>40</b>	<b>4</b>	<b>44</b>

Future minimum lease payments for buildings relate to the operating lease three month notice period with the University of Wolverhampton Science Park Ltd.

Whilst our arrangements with NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed. Consequently this note does not include future minimum lease payments for these arrangements.

### 12.2 As Lessor

The clinical commissioning group does not have any leasing arrangements as a lessor (none in 2017-18)

## 13 Property, plant and equipment

The clinical commissioning group has no property, plant and equipment (none in 2017-18)

## 14 Intangible non-current assets

The clinical commissioning group has no Intangible non-current assets (none in 2017-18).

## 15 Investment property

The clinical commissioning group has no Investment property (none in 2017-18).

## 16 Inventories

The clinical commissioning group has no Inventories (none in 2017-18).

**17.1 Trade and other receivables**

	<b>Current 2018-19 £'000</b>	<b>Non-current 2018-19 £'000</b>	<b>Current 2017-18 £'000</b>	<b>Non-current 2017-18 £'000</b>
NHS receivables: Revenue	1,466	-	1,486	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	1,022	-	882	-
NHS accrued income	1,597	-	864	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	-	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	339	-	179	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	215	-	126	-
Non-NHS and Other WGA accrued income	-	-	9	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	-	-	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	-	-	(7)	-
VAT	145	-	39	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables and accruals	2	-	4	-
<b>Total Trade &amp; other receivables</b>	<b>4,785</b>	<b>-</b>	<b>3,582</b>	<b>-</b>
<b>Total current and non current</b>	<b>4,785</b>	<b>-</b>	<b>3,582</b>	<b>-</b>

**Included above:**

Prepaid pensions contributions

NHS prepayments and accrued income include £838k in relation to the maternity pathway prepayment relating to activity with the Royal Wolverhampton NHS Trust.

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to clinical commissioning groups to commission services, no credit scoring of them is considered necessary.

The majority of other receivables that are neither past due nor impaired relate to other NHS bodies or local government.

No credit scoring of these bodies is considered necessary.

**17.2 Receivables past their due date but not impaired**

	<b>2018-19 DHSC Group Bodies £'000</b>	<b>2018-19 Non DHSC Group Bodies £'000</b>	<b>2017-18 DHSC Group Bodies £'000</b>	<b>2017-18 Non DHSC Group Bodies £'000</b>
By up to three months	115	316	805	53
By three to six months	314	-	-	-
By more than six months	33	-	5	-
<b>Total</b>	<b>462</b>	<b>316</b>	<b>810</b>	<b>53</b>

£1,272k of the amount in Note 17.1. has subsequently been recovered post the statement of financial position date.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2019.

**17.3 Impact of Application of IFRS 9 on financial assets at 1 April 2018**

	<b>Cash and cash equivalents</b>	<b>Trade and other receivables - NHSE bodies</b>	<b>Trade and other receivables - other DHSC group bodies</b>	<b>Trade and other receivables - external</b>	<b>Other financial assets</b>	<b>Total</b>
	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>
<b>Classification under IAS 39 as at 31st March 2018</b>						
Financial Assets held at FVTPL	-	-	-	-	-	-
Financial Assets held at Amortised cost	85	2,350	-	189	4	2,628
Financial assets held at FVOCI	-	-	-	-	-	-
<b>Total at 31st March 2018</b>	<b>85</b>	<b>2,350</b>	<b>-</b>	<b>189</b>	<b>4</b>	<b>2,628</b>
<b>Classification under IFRS 9 as at 1st April 2018</b>						
Financial Assets designated to FVTPL	-	-	-	-	-	-
Financial Assets mandated to FVTPL	-	-	-	-	-	-
Financial Assets measured at amortised cost	85	2,350	-	189	4	2,628
Financial Assets measured at FVOCI	-	-	-	-	-	-
<b>Total at 1st April 2018</b>	<b>85</b>	<b>2,350</b>	<b>-</b>	<b>189</b>	<b>4</b>	<b>2,628</b>
Changes due to change in measurement attribute	-	-	-	-	-	-
Other changes	-	-	-	-	-	-
<b>Change in carrying amount</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>

**17.4 Movement in loss allowances due to application of IFRS 9**

	<b>Trade and other receivables - NHSE bodies</b>	<b>Trade and other receivables - other DHSC group bodies</b>	<b>Trade and other receivables - external</b>	<b>Other financial assets</b>	<b>Total</b>
	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>	<b>£000s</b>
<b>Impairment and provisions allowances under IAS 39 as at 31st March 2018</b>					
Financial Assets held at Amortised cost (ie the 1718 Closing Provision)	-	-	-	(7)	-
Financial assets held at FVOCI	-	-	-	-	(7)
<b>Total at 31st March 2018</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>(7)</b>	<b>-</b>
<b>Loss allowance under IFRS 9 as at 1st April 2018</b>					
Financial Assets measured at amortised cost	-	-	-	(7)	-
Financial Assets measured at FVOCI	-	-	-	-	(7)
<b>Total at 1st April 2018</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>(7)</b>	<b>-</b>
Change in loss allowance arising from application of IFRS 9	-	-	-	-	-

## **18 Other financial assets**

The clinical commissioning group had no Other financial assets (none in 2017-18).

## **19 Other current assets**

The clinical commissioning group had no Other current assets (none in 2017-18).

## **20 Cash and cash equivalents**

	<b>2018-19 £'000</b>	<b>2017-18 £'000</b>
<b>Balance at 01 April 2018</b>	85	32
Net change in year	(18)	53
<b>Balance at 31 March 2019</b>	<b>67</b>	<b>85</b>
<hr/>		
Made up of:		
Cash with the Government Banking Service	67	85
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
<b>Cash and cash equivalents as in statement of financial position</b>	<b>67</b>	<b>85</b>
<hr/>		
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
<b>Total bank overdrafts</b>	<b>-</b>	<b>-</b>
<hr/>		
<b>Balance at 31 March 2019</b>	<b>67</b>	<b>85</b>

## **21 Non-current assets held for sale**

The clinical commissioning group had no Non-current assets held for sale (none in 2017-18).

## **22 Analysis of impairments and reversals**

The clinical commissioning group had no impairments and reversals (none in 2017-18).

	Current 2018-19 £'000	Non-current 2018-19 £'000	Current 2017-18 £'000	Non-current 2017-18 £'000
<b>23 Trade and other payables</b>				
Interest payable	-	-	-	-
NHS payables: Revenue	3,086	-	1,473	-
NHS payables: Capital	-	-	-	-
NHS accruals	6,875	-	5,822	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	2,385	-	5,482	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	24,612	-	21,428	-
Non-NHS and Other WGA deferred income	20	-	20	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	74	-	59	-
VAT	-	-	-	-
Tax	62	-	52	-
Payments received on account	-	-	-	-
Other payables and accruals	5,224	-	1,422	-
<b>Total Trade &amp; Other Payables</b>	<b>42,337</b>	<b>-</b>	<b>35,758</b>	<b>-</b>
Total current and non-current	<b>42,337</b>		<b>35,758</b>	

NHS accruals include £1,960k in respect of partially completed patient spells. £1,500k of this relates to activity with the Royal Wolverhampton NHS Trust.

Other payables include £84k outstanding pension contributions at 31 March 2019, (£65k as at 31 March 2018).

### 23.1 Impact of Application of IFRS 9 on financial liabilities at 1 April 2018

	Trade and other payables - NHSE bodies	Trade and other payables - other DHSC group bodies	Trade and other payables - external	Other borrowings (including finance lease obligations)	Other financial liabilities	Total
	£000s	£000s	£000s	£000s	£000s	£000s
<b>Classification under IAS 39 as at 31st March 2018</b>						
Financial Assets held at FVTPL	-	-	-	-	-	-
Financial Assets held at Amortised cost	7,295	-	28,332	-	-	<b>35,627</b>
<b>Total at 31st March 2018</b>	<b>7,295</b>	<b>-</b>	<b>28,332</b>	<b>-</b>	<b>-</b>	<b>35,627</b>
<b>Classification under IFRS 9 as at 1st April 2018</b>						
Financial Liabilities designated to FVTPL	-	-	-	-	-	-
Financial Liabilities mandated to FVTPL	-	-	-	-	-	-
Financial Liabilities measured at amortised cost	7,295	-	28,332	-	-	<b>35,627</b>
Financial Assets measured at FVOCI	-	-	-	-	-	-
<b>Total at 1st April 2018</b>	<b>7,295</b>	<b>-</b>	<b>28,332</b>	<b>-</b>	<b>-</b>	<b>35,627</b>
Changes due to change in measurement attribute	-	-	-	-	-	-
Other changes	-	-	-	-	-	-
<b>Change in carrying amount</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>

### 24 Other financial liabilities

The clinical commissioning group had no Other financial liabilities (none in 2017-18).

### 25 Other liabilities

The clinical commissioning group had no Other liabilities (none in 2017-18).

**26 Borrowings**

The clinical commissioning group had no Borrowings (none in 2017-18).

**27 Private finance initiative, LIFT and other service concession arrangements**

The clinical commissioning group had no Private finance initiative, LIFT, or other service concession arrangements (none in 2017-18).

**28 Finance lease obligations**

The clinical commissioning group had no Finance lease obligations (none in 2017-18).

**29 Finance lease receivables**

The clinical commissioning group had no Finance lease receivables (none in 2017-18).

**30 Provisions**

	<b>Current 2018-19 £'000</b>	<b>Non-current 2018-19 £'000</b>	<b>Current 2017-18 £'000</b>	<b>Non-current 2017-18 £'000</b>
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	-	-	-	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	-	-	-	-
Continuing care	22	-	37	-
Other	376	-	190	-
<b>Total</b>	<b>398</b>	<b>-</b>	<b>227</b>	<b>-</b>
<b>Total current and non-current</b>	<b>398</b>		<b>227</b>	
	<b>Continuing Care £'000</b>	<b>Other £'000</b>	<b>Total £'000</b>	
<b>Balance at 01 April 2018</b>	<b>37</b>	<b>190</b>	<b>227</b>	
Arising during the year	24	221	245	
Utilised during the year	(40)	(8)	(47)	
Reversed unused	-	(27)	(27)	
Unwinding of discount	-	-	-	
Change in discount rate	-	-	-	
Transfer (to) from other public sector body	-	-	-	
Transfer (to) from other public sector body under absorption	-	-	-	
<b>Balance at 31 March 2019</b>	<b>22</b>	<b>376</b>	<b>397</b>	
<b>Expected timing of cash flows:</b>				
Within one year	22	376	397	
Between one and five years	-	-	-	
After five years	-	-	-	
<b>Balance at 31 March 2019</b>	<b>22</b>	<b>376</b>	<b>397</b>	

The Continuing Care provision includes claims for individuals who have their care package assessed late and are entitled to a reimbursement of their nursing home fees. This late assessment is due to a delay in nursing homes advising the clinical commissioning group of the individual's placement. This is not expected to be resolved in the near future and a provision is therefore required for future cases. Costs have been estimated based on the value of cases settled in previous years and it is expected that the provision will be utilised within one year.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the clinical commissioning group. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this clinical commissioning group at 31 March 2019 is £94k.

Included within other provisions is £96k relating to estimated property charges. This is in respect of properties owned by NHS Property Services occupied by 3rd sector healthcare providers from which the CCG commissions services. Under the terms of the contracts with the providers the CCG is liable to fund property charges. This provision is expected to be settled within one year.

Other provisions also include £121k in respect of dilapidations and £21k in respect of legal fees. In addition a £77k provision has been included for a Primary Care claim for a retrospective list size increase and also £62k included for a Primary Care claim in respect of a contested taper in relation to a PMS contract.

The clinical commissioning group currently has no legal claims lodged with the NHS Litigation Authority, (nil in 2017-18).

Nil is included in the provisions of the NHS Litigation Authority as at 31 March 2019 in respect of clinical negligence liabilities of the clinical commissioning group (nil in 2017-18).

### **31 Contingencies**

The clinical commissioning group has no quantifiable contingent assets or liabilities as at 31st March 2019.

The year-end report from the NHS Litigation Authority confirms that the clinical commissioning group has no member

### **32 Commitments**

The clinical commissioning group has no commitments, Capital or Other (nil in 2017-18).

## **33 Financial instruments**

### **33.1 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 NHS clinical commissioning group is financed through parliamentary funding, it 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 clinical commissioning group 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 clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

#### **33.1.1 Currency risk**

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

#### **33.1.2 Interest rate risk**

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 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 clinical commissioning group has no capital expenditure and therefore has no exposure to interest rate fluctuations.

#### **33.1.3 Credit risk**

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

#### **33.1.4 Liquidity risk**

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

#### **33.1.5 Financial Instruments**

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

**33 Financial instruments cont'd**

**33.2 Financial assets**

	<b>Financial Assets measured at amortised cost 2018-19 £'000</b>	<b>Equity Instruments designated at FVOCI 2018-19 £'000</b>	<b>Total 2018-19 £'000</b>
Equity investment in group bodies	-	-	-
Equity investment in external bodies	-	-	-
Loans receivable with group bodies	-	-	-
Loans receivable with external bodies	-	-	-
Trade and other receivables with NHSE bodies	2,735	-	2,735
Trade and other receivables with other DHSC group bodies	328	-	328
Trade and other receivables with external bodies	339	-	339
Other financial assets	2	-	2
Cash and cash equivalents	67	-	67
<b>Total at 31 March 2019</b>	<b>3,470</b>	<b>-</b>	<b>3,470</b>

**33.3 Financial liabilities**

	<b>Financial Liabilities measured at amortised cost 2018-19 £'000</b>	<b>Other 2018-19 £'000</b>	<b>Total 2018-19 £'000</b>
Loans with group bodies	-	-	-
Loans with external bodies	-	-	-
Trade and other payables with NHSE bodies	1,156	-	1,156
Trade and other payables with other DHSC group bodies	19,523	-	19,523
Trade and other payables with external bodies	16,278	-	16,278
Other financial liabilities	5,224	-	5,224
Private Finance Initiative and finance lease obligations	-	-	-
<b>Total at 31 March 2019</b>	<b>42,182</b>	<b>-</b>	<b>42,182</b>

The carrying amount of financial assets and liabilities is considered a reasonable approximation of fair value.

#### **34. Operating Segments**

The term 'Chief Operating Decision Maker', per IFRS8, identifies a function, not necessarily a manager with a specific title. That function is to allocate resources to and assess the performance of the operating segments of an entity. The CCG's chief operating decision maker is its group of executive and non-executive officers (the Governing Body). The CCG considers it has only one operating segment: commissioning of healthcare services. Finance and performance information is reported to the Governing Body as one segment and these financial statements have been prepared in accordance with this reporting.

#### **35 Joint arrangements - interests in joint operations - Pooled Budgets**

Wolverhampton CCG entered into a pooled budget arrangement with Wolverhampton City Council on 1<sup>st</sup> April 2015. This is a section 75 (NHS Act 2006) partnership agreement relating to the commissioning of health and social care services under the Better Care Fund (BCF). The BCF has been established by the Government and it is a requirement of the Fund that the CCG and the Council establish a pooled fund for this purpose. The Host Partner is Wolverhampton City Council.

The partners' contributions to the Fund are outlined below. The share of any over/(under) spend is allocated according to the Section 75 agreement.

The CCG contributions to the Fund are outlined below. The share of any over/(under) spend is allocated according to the Section 75 agreement.

	<b>2018-19 £'000</b>	<b>2017-18 £'000</b>
<b>Pool Expenditure:</b>		
Community	28,929	30,561
Dementia	2,727	2,717
Mental Health	7,493	7,062
<b>Total Pool Expenditure</b>	<b>39,149</b>	<b>40,340</b>
<b>Funding:</b>		
Wolverhampton CCG Baseline	36,541	37,549
Wolverhampton CCG Share of Overspend	2,608	2,791
	<b>39,149</b>	<b>40,340</b>

In 2018-19, the CCG contributed £39.149m to programmes on community based provision, dementia provision and mental health provision where the CCG retained sole control.

The CCG accounted for its share of expenditure on these schemes and the contributions were fully expensed in the year.

In the 2017-18 accounts the table included the Wolverhampton City Council figures, however, due to the new presentation in the 2018-19 accounts the 2017-18 comparative figures exclude the Wolverhampton City Council figures.

#### **36 NHS Lift investments**

The CCG has no LIFT investments(none in 2017-18)

### 37 Related party transactions

During the year the following Governing Body members or members of the key management staff have declared interests with other organisations that have undertaken material transactions with the clinical commissioning group:

	Mr J	2018-19				2017-18			
		Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Dr H Hibbs; Chief Officer; Shareholder Parkfield Wolverhampton Medical Services Ltd.		0	0	0	0	2,338	0	0	0
Mr T Gallagher; Chief Finance Officer; Chief Finance Officer Walsall CCG M Hartland; Strategic Finance Officer; Strategic Finance Officer Walsall CCG Oatridge; Member of the Governing Body Walsall CCG	Mr J	939	0	173	231	59	37	74	1
Mr M Hartland; Strategic Finance Officer; Chief Finance Officer Dudley CCG		15	0	109	33	50	5	0	0
Ms H Ryan; Practice Manager Representative, Practice Manager Penn Manor Medical Centre		1,494	0	0	0	1,365	0	0	0

Page 10

The following General Practitioners were members of the clinical commissioning group Governing Body during 2018/19. Payments were made to the practices of these GPs for GMS/PMS/APMS and enhanced services delivered to the population of Wolverhampton. Other payments were also made in respect of items such as the Prescribing Incentive Scheme and collaborative fees. Payments listed are in relation to the whole GP practice and therefore do not reflect the remuneration of the individual.

#### GP Governing Body Member

- Dr D Bush, GP Member
- Dr R Rajcholan, GP Member
- Dr M Kainth, GP Member
- Dr S Reehana, Clinical Chair
- Dr M Asghar, GP Member
- Dr J Parkes, GP Member
- Dr R Gulati, GP Member



Practice	2018-19 £000	2017-18 £000
Penn Surgery	693	578
Ashmore Park Health Centre	473	432
Primrose Lane Clinic	323	354
Grove Medical Centre	1,977	1,442
Alfred Squire Medical Practice	1,241	1,225
Cannock Road Medical Practice	705	671

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a number of material transactions with entities for which the Department is regarded as the parent Department. These are:

	2018-19 £000	2017-18 £000
The Royal Wolverhampton NHS Trust	207,029	194,637
NHS Business Services Authority(Prescribing)	43,821	46,194
Black Country Partnership NHS Foundation Trust	30,725	30,318
West Midlands Ambulance Service NHS Trust	11,415	11,088
The Dudley Group of Hospitals NHS Foundation Trust	5,013	4,996
NHS England (including Arden & GEM CSU and Midlands & Lancs CSU)	1,185	1,353

In addition, the clinical commissioning group has had a number of transactions with other government departments and other central and local government bodies. Most of these transactions have been with Wolverhampton City Council, (£52,664k in 2018-19, £55,337k in 2017/18). The majority of these payments relate to the Better Care Fund pooled budget.

**38 Events after the end of the reporting period**

The clinical commissioning group does not have any events after the end of the reporting period to disclose.

**39 Third party assets**

There were no third party assets held by NHS Wolverhampton CCG (none in 17-18)

**40 Financial performance targets**

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended). NHS Clinical Commissioning Group performance against those duties was as follows:

	2018-19 Target	2018-19 Performance	2017-18 Target	2017-18 Performance
223H(1) Expenditure not to exceed income	414,727	414,685	398,281	396,125
223I(2) Capital resource use does not exceed the amount specified in Directions	-	-	-	-
223I(3) Revenue resource use does not exceed the amount specified in Directions	414,050	414,008	396,386	394,230
223J(1) Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
223J(2) Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
223J(3) Revenue administration resource use does not exceed the amount specified in Directions	5,560	5,444	5,535	5,326

Note: For the purposes of 223H(1); expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and, income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).

The final position of the CCG in 2018-19 was a surplus of £42k.

The cumulative surplus of the CCG is £10,028k.

**41 Analysis of charitable reserves**

There were no charitable reserves held by NHS Wolverhampton CCG (none in 17-18)

**42 Effect of application of IFRS 15 on current year closing balances**

IFRS15 has not had an impact within the clinical commissioning group and therefore there are no material changes on current year closing balances.

#### 43 Losses and special payments

##### 43 Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2018-19 Number	Total Value of Cases 2018-19 £'000	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000
Administrative write-offs	1	-	2	-
Fruitless payments	-	-	-	-
Store losses	-	-	-	-
Book Keeping Losses	-	-	-	-
Constructive loss	-	-	-	-
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
<b>Total</b>	<b>1</b>	<b>-</b>	<b>2</b>	<b>-</b>

##### Special payments

	Total Number of Cases 2018-19 Number	Total Value of Cases 2018-19 £'000	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000
Compensation payments	-	-	-	-
Compensation payments Treasury Approved	-	-	-	-
Extra Contractual Payments	-	-	1	110
Extra Contractual Payments Treasury Approved	-	-	-	-
Ex Gratia Payments	-	-	-	-
Ex Gratia Payments Treasury Approved	-	-	-	-
Extra Statutory Extra Regulatory Payments	-	-	-	-
Extra Statutory Extra Regulatory Payments Treasury Approved	-	-	-	-
Special Severance Payments Treasury Approved	-	-	-	-
<b>Total</b>	<b>-</b>	<b>-</b>	<b>1</b>	<b>110</b>

# Independent auditor's report to the members of the Governing Body of NHS Wolverhampton CCG

## Report on the Audit of the Financial Statements

### Opinion

We have audited the financial statements of NHS Wolverhampton CCG (the 'CCG') for the year ended 31 March 2019, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers 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 Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2019 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19; and
- have been prepared in accordance with the requirements of the Health and Social Care Act 2012.

### Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. 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 CCG 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 have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the CCG's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

### Other information

The Accountable Officer is 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 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by the NHS Commissioning Board or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement 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:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19 and the requirements of the Health and Social Care Act 2012; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG gained through our work in relation to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources, 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.

#### **Opinion on regularity required by the Code of Audit Practice**

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

#### **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 CCG, or an officer of the CCG, 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 CCG 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 Accountable Officer and Those Charged with Governance for the financial statements**

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 49 to 50, the Accountable Officer, is 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 Accountable Officer determines 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 Accountable Officer is responsible for assessing the CCG'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 CCG without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

The Governing Body is Those Charged with Governance. Those charged with governance are responsible for overseeing the CCG'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](http://www.frc.org.uk/auditorsresponsibilities). This description forms part of our auditor's report.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

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

##### **Matter on which we are required to report by exception - CCG'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 CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

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

##### **Responsibilities of the Accountable Officer**

As explained in the Governance Statement<sup>1</sup>, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

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

We are required under Section 21(1)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us

to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

## **Report on other legal and regulatory requirements – Certificate**

We certify that we have completed the audit of the financial statements of NHS Wolverhampton CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

### **Use of our report**

This report is made solely to the members of the Governing Body of the CCG, 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 members of the Governing Body of the CCG 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 CCG and the members of the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

### ***Mark Stocks***

Mark Stock  
Partner  
for and on behalf of Grant Thornton UK LLP, Local Auditor  
Birmingham  
24 May 2019

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Agenda Item No: 7



## Health Scrutiny Panel

29/10/2019

**Report title** Appointment Waiting Times and Utilisation for CoWC Health Scrutiny Panel

**Report of:** Jo Reynolds, Primary Care Transformation Manager

**Portfolio** Public Health and Wellbeing

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### Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to:

Consider and note the content of this report. Panel members are encouraged to raise any queries they may have and note that the CCG are working in partnership with Primary Care Networks to improve appointment utilisation.

## 1.0 Introduction

- 1.1 This report is intended to provide assurance to Overview & Scrutiny Panel regarding waiting times and appointment utilisation following a request made by the Panel earlier in 2019. The report provides information regarding General Practice in Wolverhampton only.

## 2.0 Background

- 2.1 Earlier in 2019 a request was made by the Overview and Scrutiny Panel that a report be presented on GP appointment waiting times. It was agreed to utilise information from the NHS benchmarking report and the GP Appointment Utilisation tool, this and further appointment information associated with Primary Care Hubs is also detailed.

## 3.0 Impact on Health and Wellbeing Strategy Board Priorities

Which of the following top five priorities identified by the Health and Wellbeing Board will this report contribute towards achieving?

- |  |                          |
|--|--------------------------|
| Wider Determinants of Health                     | ✓                        |
| Alcohol and Drugs                                | <input type="checkbox"/> |
| Dementia (early diagnosis)                       | <input type="checkbox"/> |
| Mental Health (Diagnosis and Early Intervention) | <input type="checkbox"/> |
| Urgent Care (Improving and Simplifying)          | <input type="checkbox"/> |

## 4.0 Decision/Supporting Information (including options)

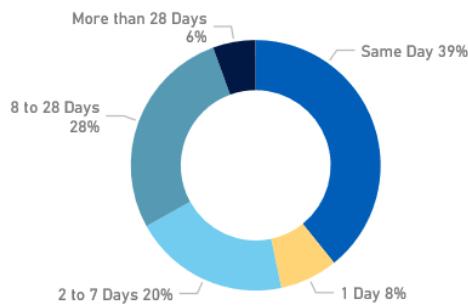
The questions the Panel are seeking to be answered, and the response to each question, are below.

### 4.1 How the CCG collect and monitor the data.

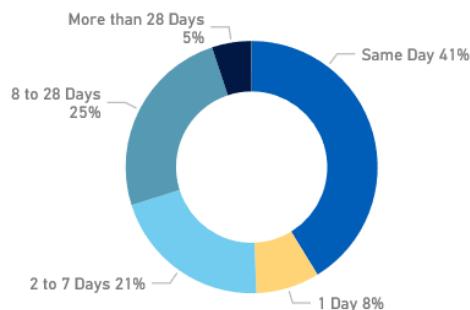
There are two forms of data available, National data is collected by NHS Digital and local data is collected for Primary Care Networks (Practices working together) Hub Access, commissioned through a Local Enhanced Service. It is the responsibility of the CCG to monitor the Local Enhanced Service that is in place to provide extended access from each Hub, which is gathered on a monthly basis.

### 4.2 How GP Appointment Waiting Times in Wolverhampton compare nationally and regionally and analysis as to the differences.

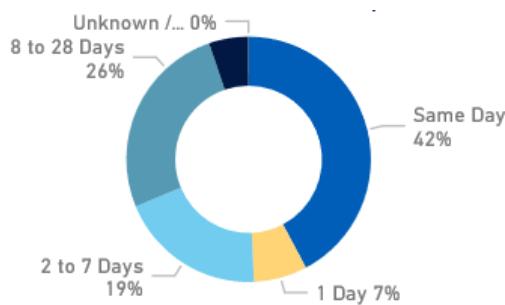
## Wolverhampton



## STP



## National Picture



The highest proportion of appointments are utilised on the same day as booking, with less than a third of patients waiting above 8 days for their appointment.

There are slightly less patients accessing appointments on the same day as booking in Wolverhampton compared to the STP and nationally.

Wolverhampton does have a slightly higher proportion of patients waiting 8- 28 days, however patient demographic needs to be considered when reviewing this.

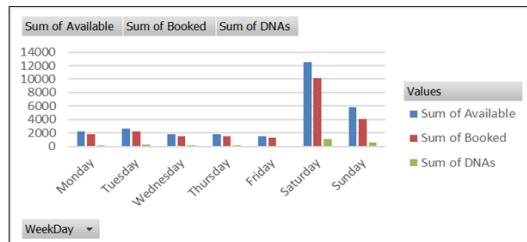
Figures can also be influenced by patient choice, and the booking of routine appointments.

Source; NHS Digital

There is no requirement for PCN Hub to collect waiting time data.

Wolverhampton Primary Care Networks	
<b>Unity East Network</b>	
• Ashmore Park Health Centre	• Dr Fowler- Oxley Surgery
• I H Medical Bilston Health Centre	• Mayfield Medical Centre
• Poplars Medical Practice	• Primrose Lane
• Probert Road Surgery	• The Bilston Family Practice
<b>Unity West Network</b>	
• Castlecroft Medical Practice	• Dr Whitehouse- The Surgery
• Pennfields Health Centre (IH)	• Penn Surgery
• Tettishall Medical Practice	
<b>Wolverhampton Total Health</b>	
• Duncan Street	• East Park Medical Practice
• Fordhouses Medical Practice	• Newbridge Surgery
• Tudor Medical Centre & Branches	• Whitmore Reans Health Centre (& Branches)
<b>Wolverhampton North Network</b>	
• Ashfield Road Surgery	• Cannock Road Medical Practice
• Keats Grove Surgery	• MGS Medical Practice
• Prestbury Medical Practice	• Showell Park Health & Walk-in-Centre
• The Surgery, Woden Road	
<b>Wolverhampton South East Collaborative</b>	
• Bilston Health Centre	• Bilston Urban Village Medical Centre
• Ettingshall Medical Centre	• Hill Street Surgery
• Health and Beyond	
• Parkfields	
<b>RWT PCN</b>	
• Alfred Squire Medical Practice	• Coalway Road Surgery
• Lea Road Medical Practice	• Penn Manor Medical Centre
• The Surgery, Wednesfield	• Thornley Street Surgery
• Warstones Health Centre	• West Park Surgery

Day of Week	Sum of Available	Sum of Booked	Sum of DNAs	% Utilised	% DNA	% Unbooked
Monday	2238	1833	175	74%	8%	18%
Tuesday	2640	2211	287	73%	11%	16%
Wednesday	1799	1532	149	73%	8%	15%
Thursday	1790	1488	176	73%	10%	17%
Friday	1494	1343	126	81%	8%	10%
Saturday	12545	10195	1095	73%	9%	19%
Sunday	5853	4081	544	60%	9%	30%
<b>Grand Total</b>	<b>28359</b>	<b>22683</b>	<b>2552</b>			



## 4.3 How GP Appointment Waiting Times in Wolverhampton compare to any national performance targets.

There are no performance targets for waiting times for either core service or hub appointments. The contractual requirements for Extended Access Hubs are that both pre-bookable and on the day appointments need to be available.

## 4.4 How the CCG are trying to improve waiting times and any national/ regional changes planned.

All practices have same day provision, with different models of managing demand. Practices report that the majority of their appointments were available on an urgent basis, in order to manage patient expectations. All practices have systems in place to manage demand and flow of patients, by releasing appointments at different times.

The majority of practices stated that appointments were able to be accessed in a number of ways, including online booking, telephone triage, and walk in clinics.

Patient requests, such as seeing a specific GP, can have a significant impact on the length of wait for an appointment.

Same day appointments, and not having appointments too far in advance, were both viewed as ways to help reduce waiting times and DNAs.

Wolverhampton CCG is supporting practices to increase the take up of Extended Access Hub appointments, and helping patients to know about the availability of the additional appointments, through an engagement improvement plan. The aim of the activity within the plan is to enable patients to make better use of Primary Care, including the appointments that they can access at hub level.

By delivering services within a Hub as a network, activity is diverted into the community reducing the need for patients to attend urgent and secondary care. Capacity is also

freed up in other practices, as the distribution of patients and the choices available is increased.

**4.5 The best and worst GP practices in Wolverhampton for waiting times with analysis as to why this is the case.**

Information regarding patient experience of booking appointments with each practice can be found in the GP survey (<https://gp-patient.co.uk>) this information is not collated or used as an indicator for contract monitoring by the CCG.

Monitoring of PCN Hub data informs which of the practices are utilising the appointments, and by how many. Waiting times does not feature in this data set.

**4.6 How the CCG deals with and monitors complaints about the waiting times**

Complaints regarding waiting times are managed by the practice. The CCG would not ordinarily be notified of any complaints this information is managed between practices and NHS England who provide periodic reports to the CCG confirming the numbers of complaints that may have been raised directly with NHS England. It is the provider's responsibility (practice) to investigate under their own complaints procedure. If the provider concludes the matter or decides resolution cannot be met, the parliamentary ombudsman details are given and the matter is handled by the Ombudsman.

**5.0 Implications**

**5.1 Financial and Resource Implications**

There are no additional financial implications to the CCG however, appointments that have not been cancelled and/or patients did not attend have been lost to the system when they could have been reallocated to reduce waiting times and improve the use of clinical time.

**5.2 Quality and Safety Implications**

Implications for patients and clinicians/clinical services have been detailed above. In addition to those points the mitigating actions being taken to achieve improvements should in turn achieve better outcomes for all.

**5.3 Equality Implications**

In line with NHS England's National Access Standards the CCG has in place a Equality Impact Assessment and action plan, ensuring that identified negative impacts are mitigated against.

**6.0 Schedule of background papers**

- 6.1 The background papers relating to this report can be inspected by contacting the report writer:

Jo Reynolds  
Primary Care Transformation Manager  
NHS Wolverhampton CCG  
[jo.reynolds2@nhs.net](mailto:jo.reynolds2@nhs.net)

# Health Scrutiny Panel

7 November 2019

**Report title** Healthwatch Wolverhampton GP Communication Report 2018/19

**Report of:** Tracy Cresswell  
Manager Healthwatch Wolverhampton

**Portfolio** Public Health and Wellbeing

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**Recommendation(s) for action or decision:**

The Health Scrutiny Panel is recommended to:

Note the attached Healthwatch Wolverhampton GP Communication Report for information.

This report is PUBLIC  
[NOT PROTECTIVELY MARKED]

## 1.0 Introduction

- 1.1 Healthwatch Wolverhampton is the independent consumer champion for health and social care. Part of our listening tour, members of the public told us that access to GP's needed to be a priority, however Healthwatch had previously carried out. Due to the changes taking place in General Practice as part of the NHS England Five Year Forward Plan we wanted to understand how the changes were being communicated to the patients and general public of Wolverhampton.

## 2.0 Background

- 2.1 Healthwatch Wolverhampton carried out a short survey to gain an understanding of the communication that is taking place across Wolverhampton from the GP's to the patients.
- 2.2 506 patients participated over a month period, the response was that 73% of patients indicated that they did not receive any communication from their practice, however the communication that was received by 27% was mainly around appointment and prescription reminders.
- 2.3 Healthwatch were informed that communication was shared through the Patient Participation Groups, so this was asked to the members of the public 76% were not aware of the PPG's, however 51% would be interested in joining one at their practice.

## 3.0 Impact on Health and Wellbeing Strategy Board Priorities

Which of the following top five priorities identified by the Health and Wellbeing Board will this report contribute towards achieving?

Wider Determinants of Health	x <input checked="" type="checkbox"/>
Alcohol and Drugs	<input type="checkbox"/>
Dementia (early diagnosis)	<input type="checkbox"/>
Mental Health (Diagnosis and Early Intervention)	<input type="checkbox"/>
Urgent Care (Improving and Simplifying)	x <input checked="" type="checkbox"/>

## 4.0 Decision/Supporting Information (including options)

There were a number of recommendations made to improve the communication to the patients and general public. Since this report was published there has been additional changes to the General Practices as part of the Long Term Plan. The report can be found on our website [www.healthwatchwolverhampton.co.uk](http://www.healthwatchwolverhampton.co.uk) .

## 5.0 Implications

There are no known implications in relation to this report.

This report is PUBLIC  
[NOT PROTECTIVELY MARKED]

## 6.0 Schedule of background papers

- 6.1 The background papers relating to this report can be inspected by contacting the report writer:

**Tracy Cresswell**  
**Manager**

Healthwatch Wolverhampton  
Freephone: 0800 470 1944  
[www.healthwatchwolverhampton.co.uk](http://www.healthwatchwolverhampton.co.uk)

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# GP communication report



# Introduction

The delivery of primary care in Wolverhampton is undergoing change as Wolverhampton CCG respond to the requirements of the NHS England Five Year Forward View. Wolverhampton CCG published its Primary Care Strategy in 2016 and as part of the strategy it detailed how it would ensure that the people of Wolverhampton receive the right treatment, at the right time in the right place.

They are going to do this through new models of care where four groups of practices working together. Primary Care Networks will be achieved by community neighbourhood teams being wrapped around local practices. Access to primary care services is between 8am and 8pm Monday to Friday and same day weekend appointments that are provided from a hub or nominated practice within the particular GP practice group.

**Q**The principle method of engagement for the changes is through the GP practices Patient Participation Groups as well as communication directly from the GP practices.

Healthwatch Wolverhampton have therefore, undertaken a project to understand how much communication patients receive from their GP practice and what levels of awareness and involvement there are with PPGs. This is in order to understand the potential effectiveness of the public engagement around the changes to primary care delivery in Wolverhampton.

This report has been shared with Wolverhampton City Clinical Commissioning Group prior to publication. Some amendments have been made as a result of their comments on the way that the practices are working together and providing access to appointments.

## Methodology

This project made use of a survey that consisted of mainly quantitative questions. There was one open ended question used in the survey.



This method of collecting data was chosen as it was an easy method to reach a relatively high number of respondents. The survey was supported on-line and the web link to the surveys was shared with the Healthwatch Wolverhampton network. In addition to this paper surveys were completed with patients at GP practices in Wolverhampton and members of the public at events that Healthwatch Wolverhampton attended over the summer months.

One small focus group was also undertaken with **5** participants whose first language was not English. Their views have been included in the results under the relevant sections of the results.

# Key findings

There were **506** respondents to the survey in total spread across most of the GP practices in Wolverhampton.

**Only 27%** of respondents said that they received regular communication from their GP practice.

Communication was mainly appointment or prescription reminders.

Some said they were told about changes in the practice such as booking appointments.

**17%** of respondents who received communication from their GP practice did so on a monthly basis, **12%** said they had communication quarterly; **9%** every six months and **9%** annually.

**18%** of respondents said that they received newsletters by post from their practice and **14%** said that they received emails from their practice. A large number of respondents indicated that they receive communication from their practice by text message.

There were a number of respondents who said that they did not want to have any communication from their practice on any subject.

Others wanted to only receive communication if it related directly to their own health, such as test results and prescription or appointment reminders.

Some wanted to receive communication about changes in their practice including staff changes, opening times and accessing appointments.

Health promotion information was also pinpointed by some respondents as being important to them including condition specific communication.

The preferred methods of receiving information from their practice were, text message, email and posted newsletter.

**Only 24%** of respondents said that they knew about their practice patient participation group.

**Only 30%** of the respondents who had heard of their PPG said that they received communication from the PPG.

When asked if they would be interested in receiving information from their **PPG** **51%** of respondents said



that they would whereas **49%** said that they would not.

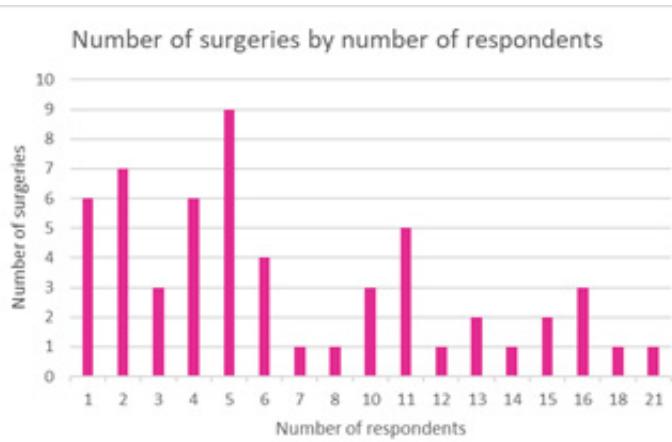
From the results of the survey it is clear that using the PPGs and the GP practices to involve and communicate with patients about the changes that are being made to the delivery of primary care in Wolverhampton means that there were large numbers of patients who are not being reached. However, it is also apparent that the information that patients want to receive is generally only that which directly impacts on them as a patient in terms of accessing appointments, being able to see the doctors that they want and reminders about appointments and prescriptions.

# Results

There were **506** responses to the survey overall. Not all respondents answered all of the questions either because they were not relevant to them or because they chose to skip the questions.

The first question asked for the name of the GP practice that the respondent was registered with. 488 respondents answered the question and there was a spread across the practices of numbers of respondents with only one practice having no respondents at all. The chart below (figure 1) shows the spread of respondents across the practices.

The principle method of engagement for the changes is through the GP practices Patient Participation Groups as well as communication directly from the GP practices.



**Figure 1**

## Communication with GP practices

There were 501 responses to the question about whether they receive any communication from their GP practice. Figure 2 shows the percentage breakdown between those that do receive communication from their practices and those that do not and only 27 % said that they did receive communication from their GP practice and 73 % said that they did not.

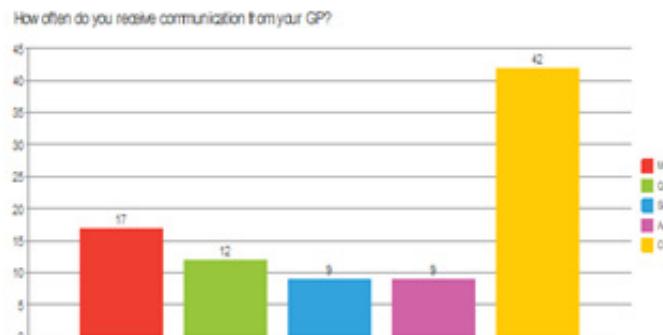


**Figure 2**

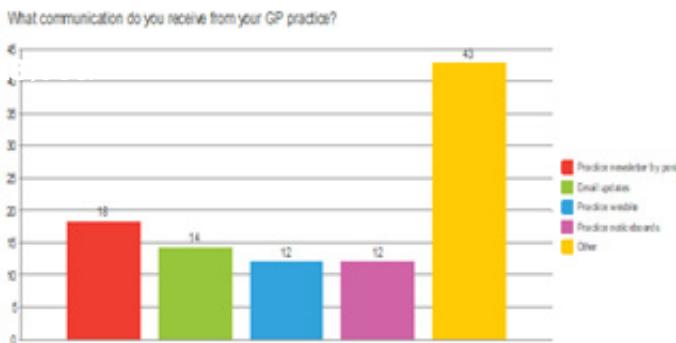
Those that said that they did have communication from their GP practice were asked how often they receive that communication. **89** respondents answered the question. Figure 3 shows the responses by percentage. The highest percentage of responses was other in terms of frequency of communication with responses ranging between frequently to never. However, most commonly the communication that they indicated was 'as and when' required, or when changes occurred such as to on-line booking systems. Many of the respondents also indicated that their communication with their GP practice related to the confirmation of appointments rather than the receipt of practice information.

**17%** said that they had monthly communication from their practice; **12%** said quarterly; **9%** said they had communication six monthly and **9%** annually.

**Figure 3**



The types of communication that respondents were receiving is detailed in **figure 4**. There were **98** responses to this question.



**Figure 4**

Again, the highest percentage of respondents were those that said other at **43%**. The next highest number was for practice newsletters by post (**18%**); **14%** said that they get email updates; **12%** said that they got updates through the practice website and another **12%** through practice noticeboards.

Those who said that the communication that they received was other, largely said that they received text messages indicating that a lot of the communication was in relation to appointments and reminders. Some of the respondents said that they only got information by accessing the practice website, or when they called or visited the practice with one saying that they got the newsletter from reception suggesting that it is not being sent to registered patients who have not visited the practice. Others received information from the practice by letter.

## Preferences for communication from GPs

Respondents were asked what type of communication they would like to receive from their GP practice.

The responses from this open text question have been themed and there are a number of common themes. A large number of respondents did not want any communication from their GP practice and there were a number who said that they only wanted communication as it directly related to them and their health, such as reminders for appointments or notification of test results without them having to contact the GP practice first.

A number said that they would like to be communicated with about changes that were going on with their practice, although only one specifically mentioned wanting information about how their practice was working with other practices as part of the clinical networks. Others were more concerned with issues such as the changes to opening times at their practices and changes to the ways that they make appointments.

A number mentioned wanting to know about changes to staffing and also about the availability of doctors. This was specifically what days particular doctors were available so that they could make appointments with a preferred doctor more easily.

Others mentioned wanting to know more about the services that their practice offered and being kept informed of changes to these, particularly in relation to health screening and checks.

Information that can be classed as health promotion was also a strong theme throughout the feedback with requests for information on groups that can be accessed for healthy living support and keeping well in the winter. Some of the participants indicated that they wanted information specifically about their own health conditions such as diabetes from their practice.

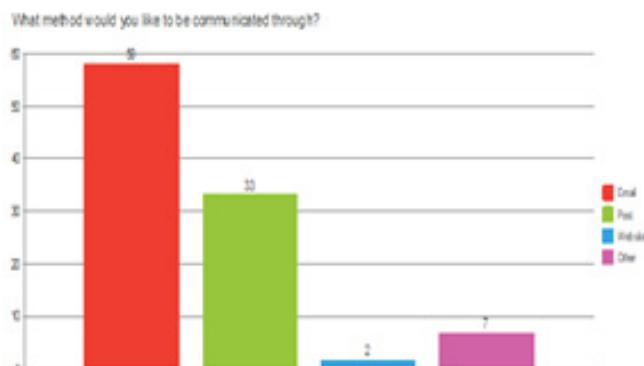
Respondents were also asked how frequently they wanted to receive communication from their GP practice. There were **330** responses to this question. **(Figure 5)**. The highest number of respondents said that they would like quarterly communication (**44%**); with **27%** saying they would like monthly communication; **13%** saying six monthly and **7%** annually. **9%** of the respondents gave the response other.

**Figure 5**



For those that answered other gave a variety of answers, however, many said that they wanted communication when there are changes that they need to be made aware of, so on an as and when necessary basis. One respondent commented that practices should ensure that they communicate changes with those who are not regular users of the practice because if they 'become ill, they do not know what the new procedures are.' Others gave a range of frequency, such as quarterly or 6-monthly but not expressing a preference for either.

When asked what method they would like to be communicated through **349** respondents answered the question. **58%** said that they would like to be communicated with by email; **33%** by post; **only 2%** through the practice website and **7%** said they would prefer other methods of communication. (**Figure 6**)



**Figure 6**

Of those that answered 'other' around half said that they would like to have communication from their practice by text message. Other respondents gave more than one preferred option such as email and post. One respondent said that they would prefer the method to be tailored to the individual patient, with them being able to give a preferred option. Another commented that practices should use 'text phones for those who are deaf.'

The members of the focus group said that they wanted to be communicated with about changes that were planned and that they wanted to be consulted about changes not just informed of changes. They suggested that there were opportunities for staff to consult them whilst they are sitting in the waiting room. They also suggested that newsletters should be posted to postal addresses so that whole families can access them.

## Patient Participation Groups

**491** respondents answered the question about whether they knew about their practice patient participation group. Only **24%** of the respondents said that they had heard of their PPG and **73%** said that they had not. (**Figure 7**).

**Figure 7**



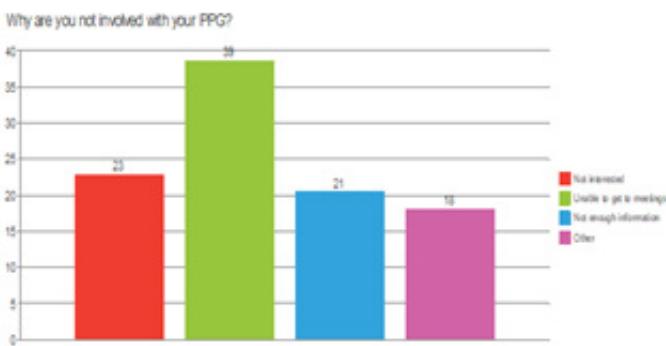
Those that had heard of their PPG were then asked if they were involved with their PPG. **113** respondents answered the question. (**Figure 8**). **24%** of the respondents said that they were involved with their PPG and **76%** said that they were not. One member of the focus group was a member of their PPG and regularly attends meetings.



**Figure 8**

**83** respondents who had heard of their PPG and were not involved with it answered the question about their reasons for not being involved. The reasons given for not being involved with their PPG were given as follows:

**23%** said that they were not interested in being part of their PPG; **39%** said that they were unable to get to meetings; **21%** said that they did not have enough information to be able to get involved and **18%** gave other as a reason. (**Figure 9**).



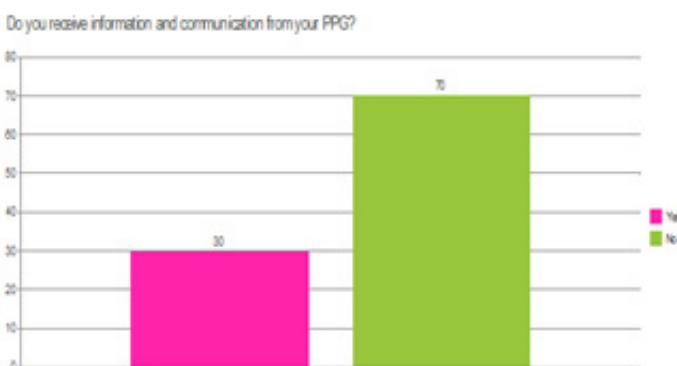
**Figure 9**

Those that gave other as an answer cited a lack of time or other commitments, such as being in full time work, as the main reasons why they were not involved with their PPG. However, there were three of the respondents who said that they had volunteered for the PPG but that they were 'never contacted.' One of them went on to say that 'you lose interest in volunteering if there is no response.' Two other respondents commented that they had tried to be involved with their PPG but one commented that it was a 'waste of time' and another saying that they had found the PPG was 'not flexible enough, nor engaged with younger or minority groups.'

The focus group members said that they were concerned that there were no translators available to assist them at PPG meetings, but also that there was no information available to them in other languages to enable them to find out about their PPG.

114 respondents answered the question about whether they received information from their PPG. **Only 30%** said that they did receive information and **70%** said that they did not receive information from their practice PPG. (**Figure 10**)

**Figure 10**



However, the final question that was answered by **460** respondents was whether they would like to receive information from their PPG. There was a relatively even split between those that wanted information (**51%**) and those who did not (**49%**). (**Figure 11**)

Would you like to receive information from your PPG?



**Figure 11**



# Recommendations

1. The findings of this project suggest that there is a gap in communication between GP practices and their patients as well as a lack of knowledge of and communication from patient participation groups. As these are the preferred ways of the CCG communicating changes about the delivery of primary care there are concerns about how many patients are missing out on communication about the changes to primary care delivery.

Therefore, we recommend that the CCG consider what other methods of communication they can utilise to communicate and engage a wider cohort of patients than simply using GPs and PPGs.

2. From the feedback that we have received it is apparent that patients want to be communicated with by their practice in a range of ways and would like that to be tailored to their preferences. We recommend that GP practices collect from their patients' preferences for communication methods in relation to updates on practice news, including an opt out.

3. When considering what communication patients want to receive, although this project was designed to consider communication in relation to change, there was feedback that patients wished to receive communication about the availability of particular staff members, and health promotion information. Therefore, we recommend that GP practices consider providing such information on a regular basis to patients.

4. It was apparent from the findings of the project that there is limited knowledge of and communication with patient participation groups for most respondents. It is recommended that practices look at how they can better inform patients of the existence of PPG's but that PPG's themselves give consideration as to how they communicate with the wider patient cohort in order to ensure that they are able to be representatives of the patients.

5. Comment was made about some respondents having expressed an interest in joining their PPGs but having had no further contact from the practice or PPG. Healthwatch Wolverhampton have collected details of people who wanted more information on this occasion and passed them to relevant practices. We recommend that these are followed up and practices look at ways that they can ensure that expressions of interest are followed up.

6. The final recommendation concerns the flexibility of the PPGs in relation to meetings and ways that they can ensure that they are representative of the community that they represent. PPGs are asked to consider other ways that they can encourage participation from a wide range of people from different backgrounds.



# Appendix 1 - GP practices where responses were received

<b>Practice name</b>	<b>Number of Responses</b>
Alfred Squire Road	10
All Saints Surgery	3
Ashfield Road Surgery	6
Ashmore Park Health Centre	4
Bilston Health Centre- Mudigonda & Mudigonda	4
Bilston Health Centre- Pahwa & Pahwa	1
Bilston Health Centre- Sharma, Walker & Mason	13
Bilston Urban Village Medical Centre	5
Bradley Health Centre- Bagary, Bagary and Manda	2
Bradley Medical Centre- Lal & New	5
Caerleon Surgery	2
Cannock Road	7
Castlecroft Medical Practice	23
Church Street Surgery	5
Coalway Road Surgery	15
Cromwell Road Surgery	1
Duncan Street Primary Care Centre	12
East Park Medical Practice	23
Ednam Road Surgery	11
Ettingshall Medical Centre	5
Grove Medical Centre	6
Heath Town Medical Centre	6
Keats Grove Surgery	25
Lea Road Medical Practice	13
Leicester Street Medical Centre	14
Lower Green Health Centre	16
Low Hill Medical Centre	5
Marsh Lane	5
Mayfield Medical Centre	10
Owen Road Surgery	10
Oxley	4
Parkfield Medical Centre	11
Park Street	2
Pendeford Health Centre- Dhillon & Raza	1
Pendeford Health Centre- Kharwadkar	4
Pendeford Health Centre- Vij, Vij, Mohindroo & Hamdy	5
Pennfields Medical Centre	5
Penn Manor Medical Centre	18
Penn Surgery	2
Poplars Medical Practice	1
Prestbury Medical Practice- 41 Dunkley Road	0
Prestbury Medical Practice- Hellier Road	16
Prestbury Medical Practice- 81 Prestwood Road West	15
Primrose Lane Clinic	1
Probert Road Surgery	11
Ruskin Road Surgery	2
Shale Street	3
Showell Park Health & Walk- in Centre	21
Tettenhall Road Surgery	4
The Newbridge Surgery	5
The Surgery- Hill Street	1
The Surgery - 199 Tettenhall Road	2
The Surgery- 40 Thornley Street	16
The Surgery- Woden Road	8
Tudor Medical Practice	11
Warstones Health Centre	26
Wednesfield	3
Wellington Road Surgery	2
Whitmore Reams Health Centre	4
Woodcross Health Centre	6
Wood Road Clinic	11

# Appendix 2 - Survey Questions

1. What is the name of your GP practice?

- » Alfred Squire Road
- » All Saints Surgery
- » Ashfield Road Surgery
- » Ashmore Park Health Centre
- » Bilston - Mudigonda & Mudigonda
- » Bilston Health Centre- Pahwa & Pahwa
- » Bilston Centre- Sharma, Walker & Mason
- » Bilston Urban Village Medical Centre
- » Bradley Centre- Bagary, Bagary & Manda
- » Bradley Medical Centre- Lal & New
- » Caerleon Surgery
- » Cannock Road
- » Castlecroft Medical Practice
- » Church Street Surgery
- » Coalway Road Surgery
- » Cromwell Road Surgery
- » Duncan Street Primary Care Centre
- » East Park Medical Practice
- » Ednam Road Surgery
- » Ettingshall Medical Centre
- » Grove Medical Centre
- » Heath Town Medical Centre
- » Keats Grove Surgery
- » Lea Road Medical Practice
- » Leicester Street Medical Centre
- » Lower Green Health Centre
- » Low Hill Medical Centre
- » Marsh Lane
- » Mayfield Medical Centre
- » Owen Road Surgery
- » Oxley
- » Parkfield Medical Centre
- » Park Street
- » Pendeford Health Centre- Dhillon & Raza
- » Pendeford Health Centre- Kharwadkar
- » Pendeford Centre- Vij, Mohindroo & Hamdy
- » Pennfields Medical Centre
- » Penn Manor Medical Centre
- » Penn Surgery
- » Poplars Medical Practice
- » Prestbury Medical Practice- Dunkley Road
- » Prestbury Medical Practice- Hellier Road
- » Prestbury Medical Practice- 81 Prestwood
- » Primrose Lane Clinic
- » Probert Road Surgery
- » Ruskin Road Surgery
- » Shale Street
- » Showell Park Health & Walk-in Centre
- » Tettenhall Road Surgery
- » The Newbridge Surgery
- » The Surgery- Hill Street
- » The Surgery- 199 Tettenhall Road
- » The Surgery- 40 Thornley Street
- » The Surgery- Woden Road
- » Tudor Medical Practice
- » Warstones Health Centre
- » Wednesfield
- » Wellington Road Surgery
- » Whitmore Reams Health Centre
- » Woodcross Health Centre
- » Wood Road Clinic

# Appendix 2 - Survey Questions

2. Do you receive any communication from your GP?

- a. Yes
- b. No

3. How often do you receive communication from your GP?

- a. Monthly
- b. Quarterly
- c. Six Monthly
- d. Annually
- e. Other (please specify)

4. What communication do you receive from your GP practice?

- a. Practice newsletter by post
- b. Email updates
- c. Practice website
- d. Practice noticeboards
- e. Other (please specify)

5. What communication would you like to receive from your practice?

6. How often would you like to receive communication from your GP practice?

- a. Monthly
- b. Quarterly
- c. Six monthly
- d. Annually
- e. Other (please specify)

7. What method would you like to be communicated through?

- a. Email
- b. Post
- c. Website
- d. Other (please specify)

8. Do you know about your Practice's Patient Participation Group (PPG)?

- a. Yes
- b. No

9. Are you involved with your PPG?

- a. Yes
- b. No

10. Why are you not involved with your PPG?

- a. Not interested
- b. Unable to get to meetings
- c. Not enough information
- d. Other (please specify)

11. Do you receive information and communication from your PPG?

- a. Yes
- b. No

12. Would you like to receive information from your PPG?

- a. Yes
- b. No



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fb: Healthwatch Wolverhampton

Agenda Item No: 9

CITY OF  
WOLVERHAMPTON  
COUNCIL

# Health Scrutiny Panel

07 November 2019

<b>Report title</b>	Public Health Annual Report 2018 - 2019	
<b>Cabinet member with lead responsibility</b>	Councillor Jasbir Jaspal Public Health and Wellbeing	
<b>Wards affected</b>	All	
<b>Accountable director</b>	John Denley, Director of Public Health	
<b>Originating service</b>	Public Health	
<b>Accountable employee(s)</b>	John Denley Tel Email	Director of Public Health 07912301095 John.Denley@wolverhampton.gov.uk
<b>Report to be/has been considered by</b>	Cabinet Member for Public Health and Wellbeing Public Health Leadership Team Housing Leadership Team Adult Services Leadership Team Cabinet Member for Housing Health and Wellbeing Together Children and Education Leadership Team Cabinet Member for Children Cabinet Member for Education Strategic Executive Board Cabinet Member for Adults Wolverhampton CCG Senior Management Team Cabinet	03 October 2019 08 October 2019 09 October 2019 15 October 2019 15 October 2019 16 October 2019 17 October 2019 21 October 2019 21 October 2019 22 October 2019 23 October 2019 30 October 2019 13 November 2019

**Recommendation(s) for action or decision:**

The Scrutiny Board is recommended to:

1. Consider how the information presented in the Public Health Annual Report 2018 - 2019 could be used to inform the Scrutiny work programme for the forthcoming year.
2. Support the onward progression of the Public Health Annual Report 2018 – 2019 for presentation to Cabinet on 13 November 2019.

**Recommendations for noting:**

The Scrutiny Board is asked to note:

1. The contents of the Public Health Annual Report 2018 – 2019.

**1.0 Purpose**

- 1.1 To present the Annual Report from the Director of Public Health (DPH) for the period 2018 - 2019.

**2.0 Background**

- 2.1 The Director of Public Health Annual Report is a statutory requirement. It is the DPH's professional statement about the health and wellbeing of their local communities.

- 2.2 The annual report aims to inform professionals and members of the public about key issues in the city, identify current priorities and highlight required action for the improvement and protection of the health of the local population.

**3.0 Director of Public Health Annual Report 2018 - 2019**

- 3.1 The Director of Public Health Annual Report 2018 - 2019 is the second annual report to follow the publication of the Public Health Vision 2030.

- 3.2 The report celebrates the commitment set out in the City of Wolverhampton Council Plan for Wulfrunians to live longer, healthier and more fulfilling lives, and recognises the commitment made to embed Public Health values and principles at the heart of the Council.

- 3.3 The report reflects on progress made to date towards the population and system level priorities set out in last year's Vision 2030. It goes on to outline additional steps we collectively need to take in the coming year which will continue to contribute to improving the health and wellbeing of local residents in the longer term.

- 3.4 Place based efforts at ward level are new to the annual report this year and are a commitment to drive forward the recent work of the Leader of the Council and the Chief

Executive that aims to work with communities, build on existing local assets and address concerns at a neighbourhood level.

- 3.5 Continued from last year are the popular ward profiles which outline the state of health 'where you live' and informs the work of the place-based programme outlined in 3.4.

#### **4.0 Questions for Scrutiny to consider**

- 4.1 How can the information presented in the annual report inform the Scrutiny response to local health and wellbeing issues?
- 4.2 What would Health Scrutiny like to see in next year's Public Health Annual Report 2019 – 2020?

#### **5.0 Financial implications**

- 5.1 Funding for Public Health is provided to the Council by the Department of Health and Social Care in the form of a ring-fenced grant.
- 5.2 The final grant allocation for financial year 2018 - 2019 was £20,769,000.
- 5.3 There are no direct financial implications arising from this report.

[MI/07102019/G]

#### **6.0 Legal implications**

- 6.1 The Director of Public Health has a duty to write, and the Local Authority has a duty to publish an annual report on the health of the local population under Section 73B (5) and (6) of the NHS Act 2006, inserted by Section 31 of the Health and Social Care Act 2012.

[TC/30102019/O]

#### **7.0 Equalities implications**

- 7.1 Equality is promoted through the Public Health Vision 2030 and throughout local Public Health programmes, functions and services. This is to ensure that they advance equality and tackle inequalities relating to health outcomes and wider social determinants of health among groups that share protected characteristics.

#### **8.1 Climate change and environmental implications**

- 8.1 There are no direct climate change and environmental implications arising from this report.

## **9.0 Health and Wellbeing Implications**

- 9.1 This report highlights health and wellbeing inequalities across the city. These inequalities are recognised and are addressed through the priorities outlined in the Annual Report.
- 9.2 Commissioned services funded by the Public Health Grant maintain a key focus on the reduction of these inequalities
- 9.3 In addition, and to affect the scale of change required, joint working with key strategic partners from across the broad health and wellbeing economy continues.

## **10.0 Human resources implications**

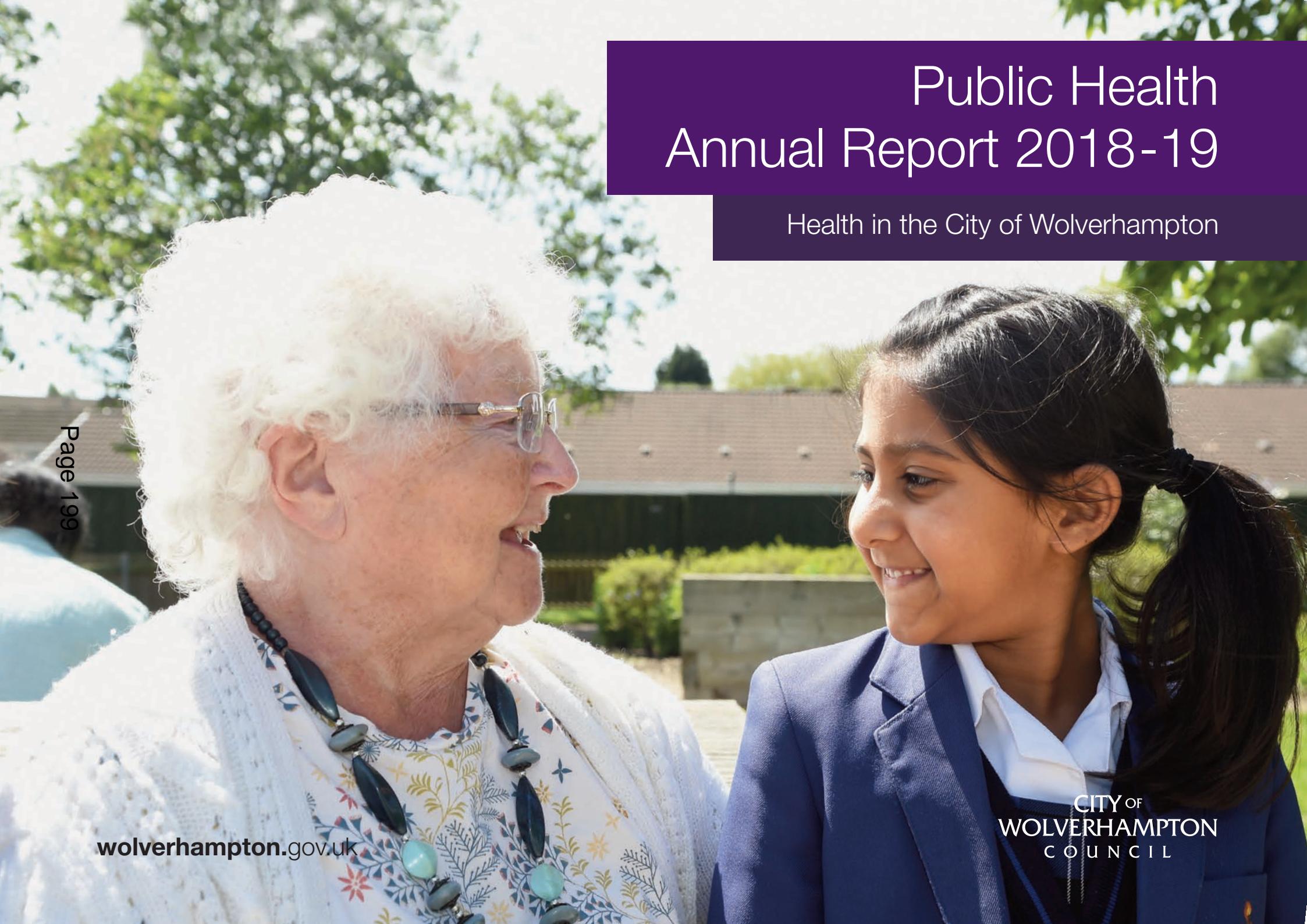
- 10.1 There are no direct human resource implications arising from this report.

## **11.0 Corporate landlord implications**

- 11.1 There are no direct Corporate Landlord implications arising from this report.

## **12.0 Schedule of background papers**

- 12.1 There are no background papers associated with this report.



# Public Health Annual Report 2018-19

Health in the City of Wolverhampton

Page 199

[wolverhampton.gov.uk](http://wolverhampton.gov.uk)

CITY OF  
WOLVERHAMPTON  
COUNCIL



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- 21 Healthy Ageing
- 25 System Leadership
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- 74 Conclusion

**Cover:** Intergenerational dementia event at Swanmore Centre, Bradmore

**Left:** WV Active Bilston - Bert Williams Disney Swim Sessions

## Foreword



John Denley  
Director of  
Public Health



Councillor  
Jasbir Jaspal  
Cabinet Member for  
Public Health and Wellbeing

We are pleased to introduce the Director of Public Health Annual Report for 2018/19.

Last year we outlined the need to rethink our approach to improving health and, in doing so, set out our Vision for Public Health 2030 – Longer, Healthier Lives. This is our commitment to helping local people stay healthy as long as possible, maintain a good quality of life, and live for longer.

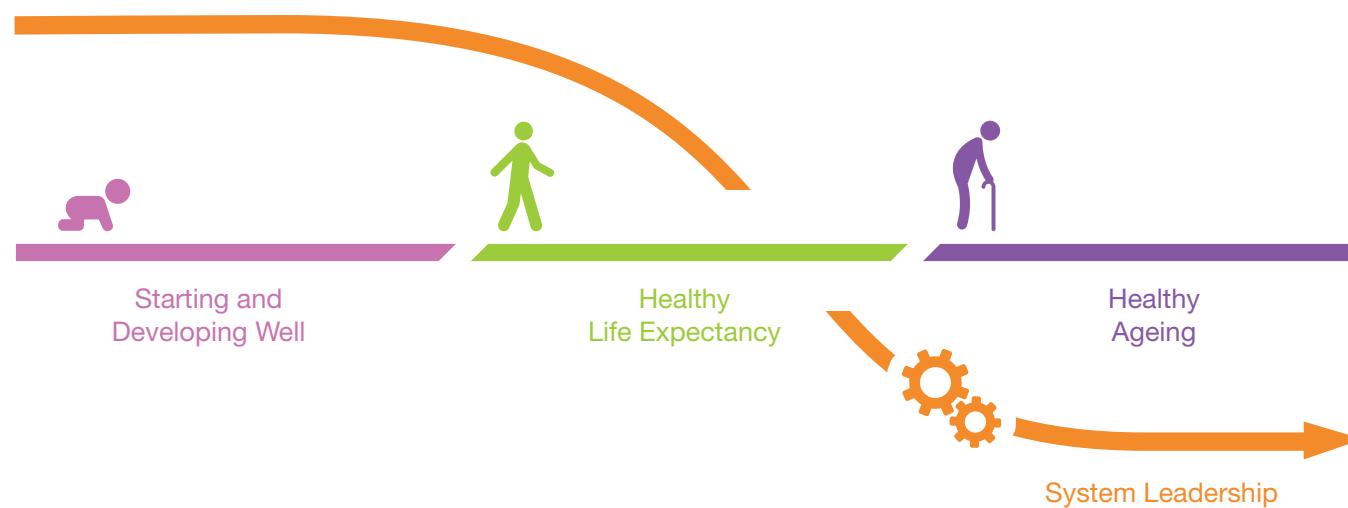
Improving health and wellbeing for the population of Wolverhampton cannot be achieved by solely focusing on individual behaviours. The complex interactions between social factors such as housing, employment, education and the environment also play a critical role in the health of our city. That's why our new approach has concentrated on getting the basics right for everyone. This means ensuring all of our residents have an equal chance of having the best start in life, an excellent education, a stable, rewarding job, and a decent home in a thriving, safe community. It also means having access to high quality health and care services.

This year we have welcomed the renewed Health and Wellbeing Together Strategy 2018 – 2023 which supports our approach to addressing the needs of local people holistically, also recognising the role of family, life opportunities, and communities as impacting on health and wellbeing. We have also welcomed the new City of Wolverhampton Council Plan 2019 - 2024, and celebrated its commitment to Wulfrunians living healthier, longer, more fulfilling lives, reflecting a real sense of Public Health values at the very heart of our city.

The Public Health Vision 2030, the Council Plan and the Health and Wellbeing Together Strategy are rightly ambitious in their commitments. The improvements we want to make will take time to achieve and we know we cannot be successful alone. Key strategic and local partners from across the health and social care economy and beyond are critical to affect positive change in our city. We have enjoyed a successful year of partnership working and look forward to building on this success in the coming year, continuing to work together to improve the health and wellbeing of the people of Wolverhampton.

## Living longer lives locally

In the Public Health Vision 2030, we outlined our commitment to making a difference to the factors that influence healthy life expectancy at a population level. These commitments travel throughout the life course from pre-conception to older adulthood – and are underpinned by system leadership, the vehicle by which we will create change.



By focusing on making sure that children have the best start to life and targeting the needs of people at critical periods throughout their lifetime we help to ensure that people can live healthier, longer lives, no matter where they are born, live or work.

This annual report sets out the progress we have made over the last year and celebrates some of our key successes. The common theme throughout these achievements is how we have worked in partnership to make change happen. Some of these successes also show how, by working together with innovative ideas, entrenched issues in our society really can be tackled and improved.

To be a healthier, happier city, we must sustain the progress we have made this year whilst further strengthening our collective efforts to improve health outcomes and reduce inequalities for particular areas and groups.

In some instances, this will require continued improvements at a system or service level. Other times, the most appropriate response will be placed based – a very localised action with our neighbourhoods or communities. One of the ways we will do this is by building on the place-based initiatives that have commenced in recent months with the Leader of the Council and the Chief Executive.

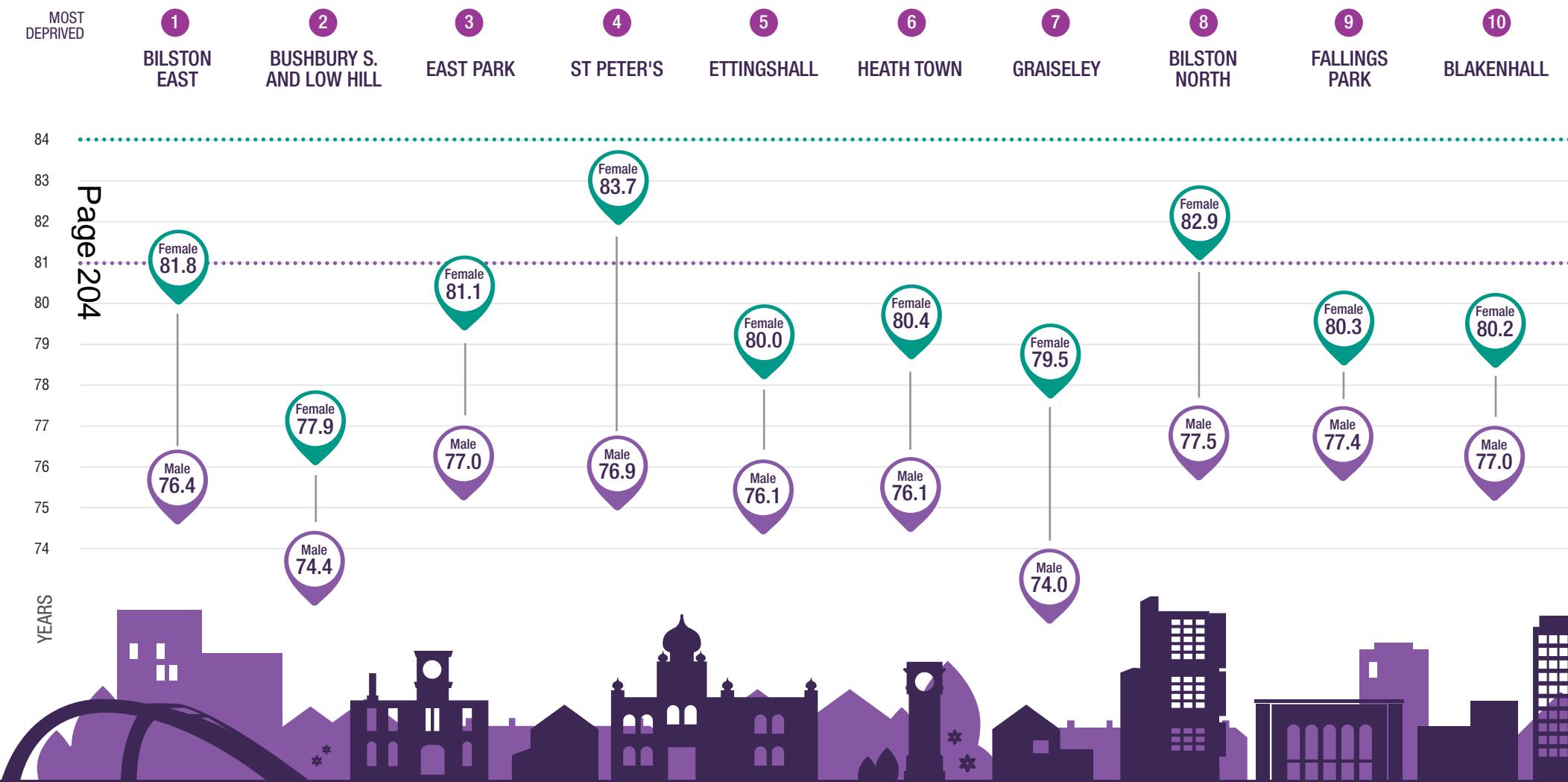


For further information and sources visit:  
[www.wolverhampton.gov.uk/public-health-vision](http://www.wolverhampton.gov.uk/public-health-vision)

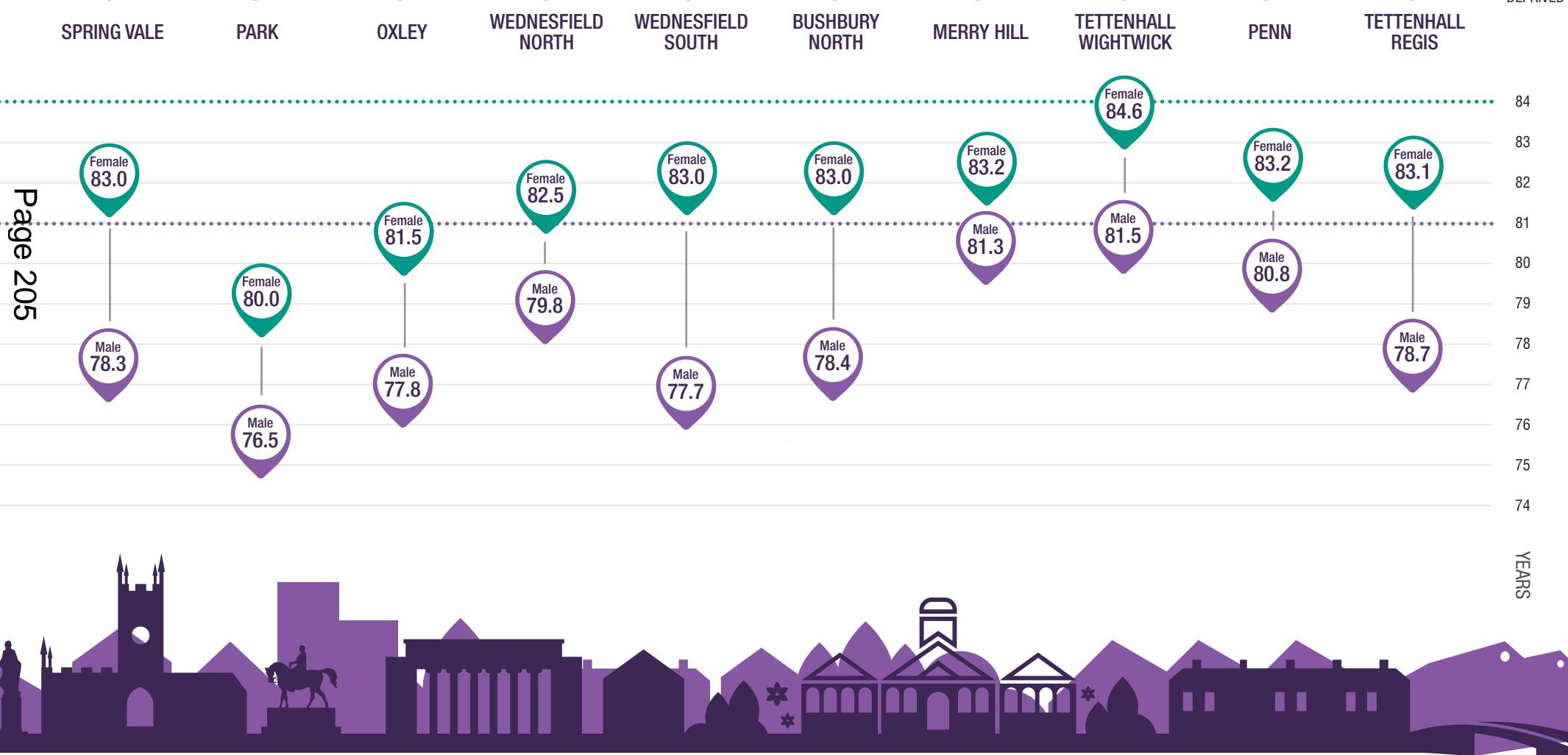
# Life expectancy at birth

There is a large difference in life expectancy in our city and people who live in less affluent areas are still more likely to die earlier. Across the city, women in Busbury South and Low Hill live on average 7 years less than women in Tettenhall Wightwick. For men, a similar gap

of 7.5 years exists between Graiseley and Tettenhall Wightwick. Women have always lived longer than men but in some areas of the city, this gender difference is particularly prominent. In St Peters, women live on average 6.8 years longer than men in the same area.



It is vital that we address such significant variation across the city as the effect of this can be seen at all stages of life, starting in childhood.





# Starting and Developing Well

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## Why is this important to us?

To have the best possible start to life, a baby's mother needs to be healthy before, during and after pregnancy.

A child's experiences in their early years have the potential to significantly impact their physical and emotional health, as well as their life chances, as children and as adults.

## What do we know?

- In the past decade, the number of babies born in Wolverhampton has **increased by 6%**, to 3,537 in 2017.
- There are now an estimated **83,434 children and young people** aged 0 – 24 years living in Wolverhampton.
- Nearly a third of local children aged 0 – 15 years are **living in poverty** (31.3%).
- There are considerably more babies born to **mothers under the age of 20** in the city (23.2 per 1,000 women) than in England (13.5).
- There are **380 homeless families** in the city – equivalent to 3.6 families per 1,000 households.
- **One in six** local children and young people aged 0 - 24 have Special Educational Needs and Disabilities (SEND) (17.0%).
- There are more **children in the care of the council** in the city (110.6 per 10,000) than in England (62.0).

**Left:** Rocket Pool Strengthening Families Hub

## Starting and Developing Well

**Fewer babies  
are dying  
before their  
first birthday**



- Our infant mortality rate is **5.8 per 1,000 live births**, lower than the regional rate for the first time, but still higher than we aim to be.

**Our response:** We have developed and piloted a preventative pre-conception education package for young people aged 16-18, focusing on key messages essential for a healthy pregnancy. 'Choose Healthy, Choose You' will be rolled out to all secondary schools next year.

- Almost **one in five new mothers are smokers** at the time of delivery (17.7%).

**Our response:** We have delivered training to maternity staff to enable them to better support women to quit smoking while pregnant.

**Health Visitors  
are supporting  
more families**



- To make sure children are ready for school, we need to identify and address their health needs. Locally, **61.5% of children receive a health review** at age 2 - 2.5 years.

**Our response:** We have supported the digital transformation of the Healthy Child Programme 0-19 service, enabling Health Visitors and School Nurses to spend more time with families, giving us a better understanding of the needs of children, while Public Health Associates have been introduced to increase the number of families that receive universal health reviews.

- 27.6% of children** in Reception are overweight or obese. By Year 6, this rises to 42.9%.

**Our response:** We have created data profiles for all schools illustrating key public health outcomes. Making better use of the data available to us has highlighted healthy growth as a priority and has resulted in the initiation of a system wide response.

- Good progress made in recent years in reducing under 18 conceptions is beginning to slow.

**There are 28.1 conceptions per 1,000 females aged 15-17 in the city – the second highest rate the region.**

**Our response:** We are working with School Nurses, Embrace Sexual Health Service and the Care Leavers' Transition Team to help young people in or leaving care – who are typically at increased risk of becoming young parents – to prevent unplanned pregnancy and develop healthy, positive relationships.



*Improved access to Sexual Health services*

Too many of our children who achieved their expected level at the end of Primary School are not then achieving the national expectations at GCSE.

**Our response:** We have undertaken our third assessment of the education attainment gap for secondary school pupils. The key recommendation has been to strengthen the coming together of Public health and the School improvement team. This will be to pool knowledge and skills going forward to jointly work on strategies to support children and their educational attainment.

- Early identification of young people who are at risk of offending is a priority so we can help prevent them from carrying bladed weapons and committing violent acts.

**Our response:** Young people who are at high risk of offending and particularly those involved in serious and violent offending are often highly vulnerable, with complex needs. Identifying and helping these young people as early as possible is a priority.

- There are 2,165 cases of chlamydia per 100,000 young people aged 15-24 in Wolverhampton.

**Our response:** We have worked closely with Public Health England and Embrace Sexual Health Service to improve the chlamydia detection in young people, with our detection rate going from one of the worst in the region to second best in 12 months.

## What are we going to do next?

- Work with colleagues in Education to ensure all schools are ready for **Personal, Social, Health Education (PSHE)** to become a mandatory part of the curriculum in September 2020.
- Work in partnership with Royal Wolverhampton NHS Trust to encourage system transformation, secure workforce stability and strengthen our joint focus on improving outcomes for our local residents through the **Healthy Child Programme** and **Sexual Health** services.
- Work closely with colleagues in Housing to **improve accommodation outcomes for the most vulnerable people in our city**. This will include improving the quality of private rented homes, continuing to reduce rough sleeping, and addressing the increase in homeless families in the city.
- Develop a strategic, system-wide response across the city to ensure children and young people can grow healthily. Work with West Midlands Combined Authority on progressing the regional focus on obesity prevention, to support us in our **Healthy Growth** agenda.
- Lead the implementation of the new **Black Country Child Death Overview Panel** across Wolverhampton, Dudley, Sandwell and Walsall to review child deaths and apply learning across the area. This will include hosting the Black Country Child Death Coordinator.

## Focus on...

### Real time information

In January, the Healthy Child Programme (HCP) changed from a paper-based system of organising and recording work with families to an electronic system which allows staff to input and retrieve data in real time. This begins to paint a picture of every child's development in the city and we will be able to monitor the impact of any extra help they may receive. As our knowledge of how our children are developing improves and we understand the extra help they need, we can be more systematic in what is provided, meaning more children should receive the help they need in a timely way. Over time, we will be able to track their early development into achievements in school and assess what support helped and if there are gaps.

Another big benefit of being digital is the potential to link aspects of maternity and HCP records so that any concerns about child safety can be shared and acted on. This will help to safeguard our children.

## Focus on...

### Chlamydia diagnosis improvement

Public Health England (PHE) recommends that local authorities should be working towards achieving a detection rate of at least 2,300 per 100,000 population aged 15 to 24. The chlamydia detection rate in Wolverhampton in 2016 was 1,747 per 100,000 - lower than the regional and England average.

By working in partnership with the Embrace Service, we undertook a review of the chlamydia care pathway. We jointly identified where improvements could be made. The focus was put on increasing uptake in specialist services and community settings and on improving systems that capture activity.

As a result, we have significantly improved the detection rate to 2,165 per 100,000 in 2018. This is higher than the England average, and Wolverhampton has the second highest detection rate in the region.

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# Healthy Life Expectancy

Page 213

## Why is this important to us?

As we continue to both work and live longer, how long we spend in good health becomes increasingly important.

A rise in life expectancy does not automatically lead to a similar rise in years spent in reasonable health. Addressing lifestyles and giving people the right support to stay healthy and independent is crucial to improving healthy life expectancy.

## What do we know?

- Life expectancy varies greatly across Wolverhampton – from the West to the East, a distance of some seven miles, **life expectancy falls by around seven years**.
- Cardiovascular disease (CVD), along with cancer and respiratory disease, **are the top three causes of death** in Wolverhampton.
- **People who sleep out on the streets** often experience barriers to accessing quality health and care services and experience poor outcomes.
- Alcohol has a significant effect on life expectancy and mortality. Our **alcohol specific mortality rate of 20.6 per 100,000** is almost double the rate seen nationally (10.6).
- **Mental health is integral to our overall health** and is fundamental to growth, development, learning and resilience. The conditions in which we live, grow, work and age all affect our mental health and wellbeing.

Left: Walk for Health Group at Bantock Park

## Healthy Life Expectancy



The City of Wolverhampton has the lowest physical activity rates in the West Midlands. **More than a third (37.1%) of our adult population are doing less than 30 minutes activity per week.** Low physical activity is one of the top 10 causes of disease and disability in England.

**Our response:** We have worked with national governing bodies of sport to develop accessible community spaces for competitive sport and informal physical activity. This has included attracting external funding and developer contributions to deliver projects such as new football pitches, walking tracks, and a three-lane

Strengthened community relationships by increasing opportunities for meaningful interaction and engagement

New family hub to improve engagement with drug and alcohol treatment and recovery services

Our alcohol specific hospital admissions for adults and drug prevalence estimates are higher than the national average.

**Our response:** Recovery Near You have helped 902 people to successfully complete treatment for alcohol dependence and 492 people for drug dependence. 85 people were helped to gain employment and 129 people had a housing problem resolved by the end of their treatment.



In recent years the uptake of the local **NHS Health Check programme** has declined, placing Wolverhampton in the 15 Authorities in the country with the lowest results.

**Our response:** This year 11,000 residents were invited for a check, 7,000 more than the previous year, and nearly 6,000 residents had it, compared to 3,500 in 2017. We are now one of the top performing authorities in the country.

People who sleep rough on the streets have significantly poorer health outcomes and have an average life expectancy of 47 years old. Earlier this year, the number of people sleeping rough in the city peaked at 33.

**Our response:** The multi-agency Rough Sleeper Operational Group, chaired by the Director of Public Health, has been established and meets frequently. It takes a person-centred approach to working with and accommodating people who are sleeping rough in the city.

- Domestic abuse seriously impacts individuals, their children and families, as well as the wider community. It is estimated that more than **51,000 people in our city will experience domestic abuse** in their lifetime.

**Our response:** This year's Tackling Interpersonal Violence and Abuse including Violence against Women and Girls Strategy 2019 -22 has a stronger emphasis on prevention. It focuses on limiting the impact of domestic abuse by identifying and responding to people who experience domestic abuse at the earliest opportunity, as well as strengthening the criminal justice response to offenders.

- During the last year WV Active leisure centre membership and usage levels have **risen to their highest levels**, thanks to a new membership strategy which has helped reduce barriers to entry including cost.

**Our response:** We've broadened the leisure offer to encourage a wider age of customers, from free swimming for under 17s to Aqua and Pilates classes for the older population groups. Working with national governing bodies, we've increased levels of physical activity in the city, including the number of children learning to swim.

- On average, the City of Wolverhampton has **11.0 premises licensed to sell alcohol per square kilometre**. This density of alcohol outlets is the highest across the West Midlands and significantly higher than England average (1.3). We know that the availability of alcohol impacts on consumption levels.

**Our response:** We have developed an interactive tool that provides a comprehensive picture of alcohol density and alcohol related harm, enabling informed, evidence-based responses to alcohol licence applications.

Coordinated the multi agency city-wide strategy to improve suicide prevention

- The **Joint Public Mental Health & Wellbeing Strategy 2018 - 2021** from City of Wolverhampton Council and Wolverhampton Clinical Commissioning Group sets out a shared vision for every resident to have the best mental health that they possibly can at every stage of their lives, and how work to improve mental health and wellbeing extends beyond service provision and into wider public service and community settings.

**Our response:** We have developed a framework for working more effectively in partnership to act on the social, environmental and economic determinants of health to create mentally healthy places and keep people well, to increase access to employment for people with mental health

## What are we going to do next?

- Ensure that our leisure provider, **WV Active**, has an offer that meets the diverse needs of our residents, particularly looking at branching out from leisure centres to other parts of the community, and reaching out to engage more people who are currently inactive.
- Enhance future delivery of the WV Active model and the broader leisure infrastructure to include our parks, community centres & wider networks.
- Conduct an equity audit of **NHS Health Checks** to make sure that all parts of the population are taking up the offer for cardiovascular screening, and ensure that the services we commission are accessible to all regardless of ethnicity, sex, and geographical area.
- Following the development of the **Black Country Reducing Reoffending Strategy** there will now be a focus on developing a sub-regional model to support its implementation. An analysis will be completed to identify any gaps in service and a business case will be developed for regional resources to meet identified need.
- Recognising that the harms caused by substance misuse cannot be tackled in isolation, the newly formed **Substance Misuse Partnership** will bring together a wide range of agencies to address key issues effecting local people. This will include a focus on the co-existence of alcohol, drug and mental health problems which remains a significant and complex challenge.

## Focus on...

### NHS Health Checks

The NHS Health Check Programme is commissioned by Public Health and offers a fantastic opportunity to help people live longer, healthier lives.

Our poor uptake over the past five years meant that less than one in five eligible residents had their health check. This led to a change in delivery of the programme to a GP only model, allowing us to work more efficiently and effectively. We worked with local GPs to develop new ways of delivering health checks, ensuring that the right systems are in place to increase numbers of people being invited for and attending their health check appointments. This work includes building templates into the GP computer system, providing “point-of-care” finger-prick blood testing for instant test results, and providing GPs with regular feedback on progress.

Of those who had their Health Check this year, it is estimated that almost 1,000 people were identified as having a high risk of developing a heart attack or stroke over the next 10 years, 200 were diagnosed with high blood pressure and 75 were diagnosed with undetected Type 2 Diabetes.

## Focus on...

### Rough sleeping

The Rough Sleeper Operational Group was established to proactively address the rising number of people sleeping rough in the city. This multiagency collaboration between Housing, Public Health, and wider partners has led to a significant reduction in rough sleeping locally.

The offer of holistic, person-centred support for some of our most vulnerable people has led to positive improvements in accommodation, health and employment outcomes along with increased engagement with support services.

There have also been Days of Action where partners undertake co-ordinated rapid response outreach work, and raise public awareness of the Wolverhampton Alternative Giving Campaign. Contributing to the priorities of the Wolverhampton Homelessness Prevention Strategy 2018 – 2022, the partnership has won the Association for Public Service Excellence (APSE) Award for Best Collaborative Working Initiative with other Public or Third Sector Organisations. We have also been highly commended for two Municipal Journal awards - Delivering Better Outcomes and Transforming Lives.



# Healthy Ageing

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## Why is this important to us?

Living well physically and mentally is just as important in older age as it is in any stage of our life. Older age can provide us with opportunities to re-connect with family and friends, old and new hobbies, and the wider community.

We want to help shape Wolverhampton into a city that truly embraces ageing, with a health and care system that is proactive and forward thinking, supporting older adults and carers alike to meet their health and wellbeing needs in the community.

## What do we know?

- **The ageing population in Wolverhampton is growing.** There are 44,000 people over the age of 65 - nearly 17% of our total population. Projections tell us that this will grow to around 52,000 by 2030.
- An estimated 10,000 over 65s have **moderate or severe frailty**, with over 2,500 being defined as severe. Frailty affects this age group in terms of both physical and mental wellbeing.
- As of December 2018, **4.81% of over 65s, 2,171 individuals, were diagnosed with dementia in Wolverhampton**. This is higher than both England (4.33%) and West Midlands (4.14%) averages. In 2018-19, 817 per 100,000 of over 65s had permanent placements in residential or nursing care.
- Over **10% of over 65s** also report feeling a lower than average level of wellbeing.
- Only **31% of adult carers** who are over 65 have as much social contact as they would like, compared to 38% nationally.

Left: Wolverhampton Patient Advisory Cancer Team (WPACT)

## Healthy Ageing



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Historically there has been poor uptake of the flu vaccination (including over 65s, under 65s at risk, children and pregnant women) placing Wolverhampton below the England averages.

**Our response:** Despite recent vaccine shortages we have managed to maintain uptake in the over 65 group.

We have worked with the Royal Wolverhampton NHS Trust and Wolverhampton CCG to provide more opportunities for pregnant women to be vaccinated.

We were also the most improved local authority for school aged flu vaccinations in the West Midlands last year, thanks to our Flu Fighters campaign.



- Informal carers, often family and friends, provide fantastic support for older people. This can be rewarding but also very challenging; mentally, socially and financially.

**Our response:** A citywide Carer Action Group has been established to deliver a public health approach to carer wellbeing. This group is made up of key stakeholders such as Wolverhampton CCG, Adult Education Service and local voluntary sector organisations. This forms a key part of the city's strategy for strong, resilient communities.



- With more older people in the city, it is important to diagnose and respond to frailty to help them live well for longer.

**Our response:** We have produced an integrated, proactive community model to improve health and wellbeing for people living with frailty – demonstrating key partnership working with an aim to meet the needs of the population.

## What are we going to do next?

- In the coming year, we will be working with local and regional NHS providers to improve access to **cancer screening** in the City of Wolverhampton, engaging the public in system redesign and development, and striving to recognise and remove barriers. Cancer remains one of the biggest causes of early death in the city, and we are keen that we help restore as many of these life years as we can with screening systems that are as accessible as possible.
- We are also keen to further support the implementation of the **local Frailty Strategy**, and will play a leading role in bringing together the council, NHS, Voluntary Sector and wider society to meet the needs of frail adults to help keep them living well for longer.
- We will be widening access to **flu vaccinations** with our partners in the NHS and Pharmacy Sector.
- We will work with colleagues in Adult Social Care to co-produce the new **Carers Strategy**.



## Focus on...

### Flu Fighters

Flu remains a serious health concern for the population, specifically those at higher risk of complications.

Improving vaccination amongst children is vital, as generally this age group will have poor hand and respiratory hygiene which increases the risk of contagion, particularly in the most vulnerable groups including the over 65s.

Consequently, a successful campaign was carried out to increase flu vaccine uptake within school children. The campaign, badged Flu-Fighters, produced a child friendly booklet using comical characters to convey key messages around the risks and preventative action we can take against flu. Forging positive relationships with schools and education sector partners, 28,000 Flu Fighters booklets were delivered and distributed across all primary schools in the city. This led to improved uptake of flu vaccination across all school age groups, with an overall increase of uptake by approximately 3,700.

Flu Fighters has been recognised as good practice and subsequently rolled out across the Black Country. Other local authorities have also shown an interest in running the campaign in their areas. We hope to widen the reach of the campaign in the coming years.

## Focus on...

### Strategic vision for frailty

More and more people across the city will become severely frail unless we can delay or reverse the onset and progression of frailty at an earlier stage.

Our leadership in the development of a new strategic vision for frailty has enabled us to embed a population approach to preventing frailty and intervening early when risk factors are detected. This will support people to live well for longer.

We have worked collaboratively with stakeholders to shape the role of frailty co-ordinators who will work closely across newly configured Primary Care Networks (PCNs). These co-ordinators will support care teams to work collaboratively to meet the outcomes most important to patients. We have also developed a holistic measure for patient outcomes based on patients' preferences including improving independence, increasing levels of social contact and ensuring dignity in the way their care is delivered to improve people's quality of life.

# System Leadership

Page 223

## Why is this important to us?

System leadership is about supporting the public health team, the council and the wider integrated care alliance across the city to improve health outcomes for our residents. This year we have made a significant start in this area by setting up a joint population health unit with the Royal Wolverhampton Trust.

We work across organisations to help influence our partners' ability to work together to plan care delivery, promote health and assess the impact of behaviour change initiatives using innovative approaches and technology. From the 2030 Public Health vision there are three key domains of system leadership which will frame the direction of our work over the coming year.

## Embedding Public Health

Public health provides insight into local people's health needs as well as designing practical ways of working that enable organizations to maximize their role in promoting the wellbeing of the local population. Our work this year has included:

- Helping organisations understand their role in promoting health and wellbeing
- Enhancing the way services and care are provided to maximise health impact
- Using existing data systems to capture changes in health behaviours
- Measuring system wide progress to improve health and reduce health inequalities across the city.

## Embedding self-help strategies for behaviour change

We know from our lifestyle survey in 2016 that smokers who want to quit would prefer to do so using convenient and easy to access self-help tools. We developed a solution which has enabled GP's to provide self-help prescriptions to smokers bringing together a range of on-line resources and quit tools, making it easier for people to go smoke free.



## Joint Intelligence

There are a growing number of people with complex medical conditions who rely on care and support from different agencies. Helping organisations use data across various care settings to direct population prevention initiatives and care delivery requires a change in the way the Public Health intelligence resource is utilised. Our response has been to develop a joint intelligence unit between the local authority and the local

NHS Trust helping decision makers to think more clearly how services can wrap around a person effectively to meet their complex needs.

Our highly skilled team is positioned to:

- Provide population health analysis of integrated care data to shape decision making
- Help organisations tackle some of the big strategic questions
  - Are the right people receiving services at the right time or can we intervene earlier?
  - Are there groups within Wolverhampton who experience poorer outcomes?
  - Have the changes we made resulted in any difference?
  - What would happen if we invested more of our budget in a different part of the pathway?

The answers to these questions will help to improve the decisions that are made about health and care provision across the city in years to come, laying the foundations for better population health outcomes in the future, by working better together.

## Working together to improve health outcomes

No agency or organisation in isolation will be able to tackle the causes of poor health and inequalities in our city.

The Health and Wellbeing Board brings together partners including NHS, police, university, voluntary sector and others. It's their job to set priorities for collective action across the city to improve health and wellbeing. Public health system leadership brings a distinct contribution to the board's ability to improve population health outcomes through its broad focus on all aspects of health and wellbeing, including the social and economic determinants of health.

- Public Health has led the publication of the new Joint Health and Wellbeing Strategy (JHWS) for the city this year. This included using insight from the Joint Strategic Needs Assessment which summarises what the data tells us, guidance from interviews with board members, and priorities from national and local strategies.
- The priorities were tested out through a public consultation which attracted over 1,200 responses. We provided local people with a chance to have their say about the things that would help to keep them well and healthy. People told us the kind of things that improve their health and wellbeing are feeling safe, access to green spaces, work, good housing. This aligns with the approach we set out last year in the Public Health vision which strengthens our resolve to embed system wide approaches to improve the wider determinants of health.

## What are we going to do next?

In the coming year we will look to further diffuse system leadership approaches across care sectors to improve population health outcomes and reduce health inequalities. Areas of key focus will include:

- **Facilitating a ‘cultural shift’ in the way tobacco use is perceived across the Royal Wolverhampton NHS Trust:** By supporting our strategic partners ambitions to create a smoke free environment for staff, patients and visitors to the hospital site we can help reduce exposure to second hand smoke and reduce tobacco related inequalities in health across the city.
- **Mapping end of life care across the city:** We will be leading innovative work that links data from different parts of the system to consider the birds eye view of care provided in the last year of life and patterns of health and social care usage to maximise resources and improve care design.



## Place-based Public Health

In recent months, there has been a real focus on working with local communities, building on the assets that they already have, and addressing concerns raised in and about their neighbourhoods.

The Leader of the Council and the Chief Executive have championed a place-based approach to doing this and we have allocated funding for each ward in the city to support this way of working.

To use these funds most effectively, local partners are being called to action to bring about co-ordinated and sustainable change. This way of working is being developed in partnership with a range of key stakeholders including Wolverhampton for Everyone, a social movement to create positive change.

An update on this work will be part of next year's annual report.



**WOLVERHAMPTON  
FOR EVERYONE**

**Left:** Community litter pick in Fordhouses with equipment provided by City of Wolverhampton Council  
**Above right:** Wolfie at a community event in the Avion Centre

## Focus on...

### Avion Centre

The Avion Centre is a shopping precinct in Whitmore Reans which experienced an increase in anti-social behaviour over the summer of 2018. Concerns about community safety were raised by local residents, business and councillors, and reinforced by findings from the bi-annual health related behaviour survey which captures the view of local school children. In response, a Public Health led Task and Finish Group was established bringing together stakeholders from the council, West Midlands Police, voluntary and housing

sector. Through collective action, this group has successfully used enforcement powers to tackle fly-tipping and improve the physical environment, worked in partnership with local business to make changes to the way licensed premises sell high strength alcohol, secured funding to close, infill and re-landscape the subway and installed CCTV.

Working with local community and faith groups, two highly successful events have taken place at the precinct,

bringing local people together. Public Health funding has been used to run a series of events at the Whitmore Reans Library including an arts programme, delivered by the Newhampton Arts Centre, to increase local participation in the Summer Reading Challenge. Future events are being planned, including a partnership event to celebrate the positive contribution of local people to the community.

## Ward profiles

To be effective as system leaders, affecting change across the life course, and with our place-based efforts, it is important to understand the key differences in health, care and social factors across the city.

The next section includes a profile of each ward in the city. Each profile provides rich information about the health benefits and challenges that are experienced by people living in the area.

These profiles inform our place based public health work described in the previous section.

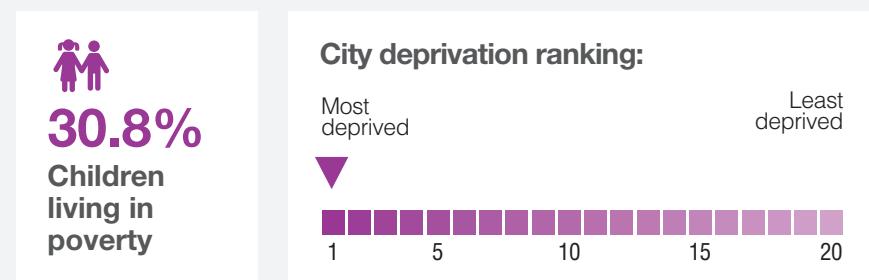
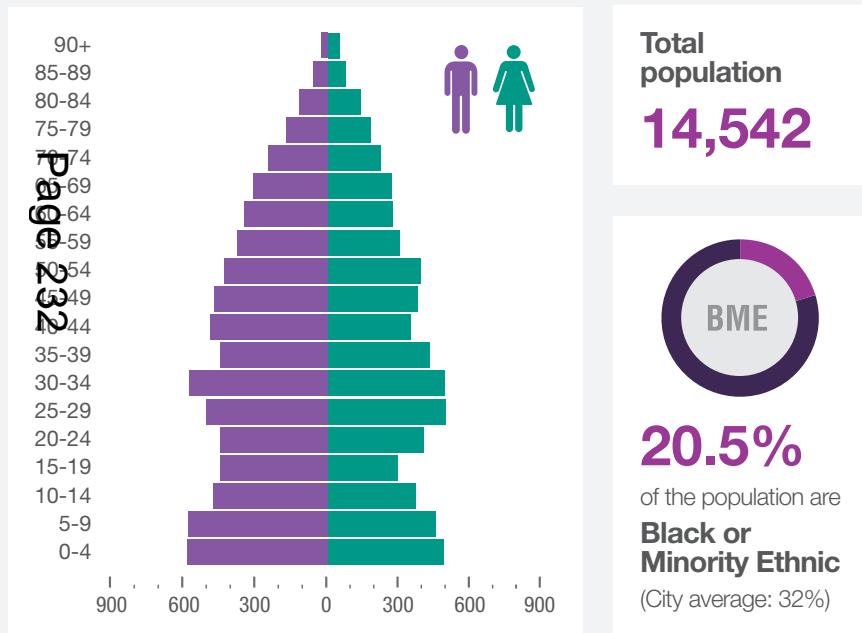
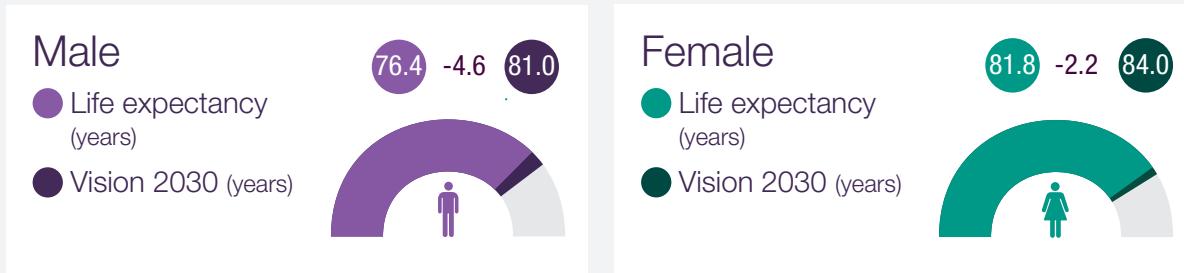
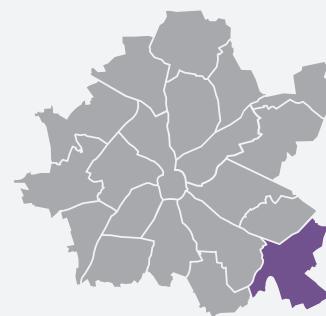
*The next section includes a range of indicators by ward which inform the ward based work that has been described above.*



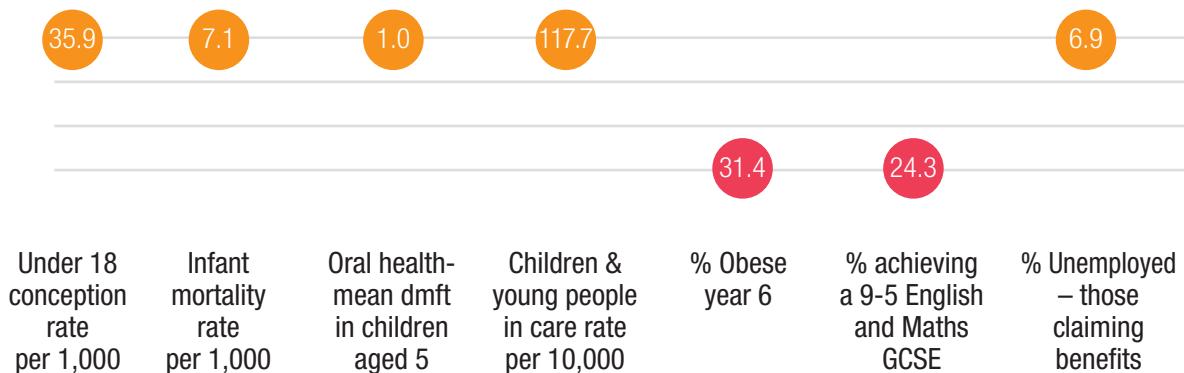
For further information and sources visit:  
<https://insight.wolverhampton.gov.uk>



## Your ward at a glance: **Bilston East**



## What is life like in your ward?





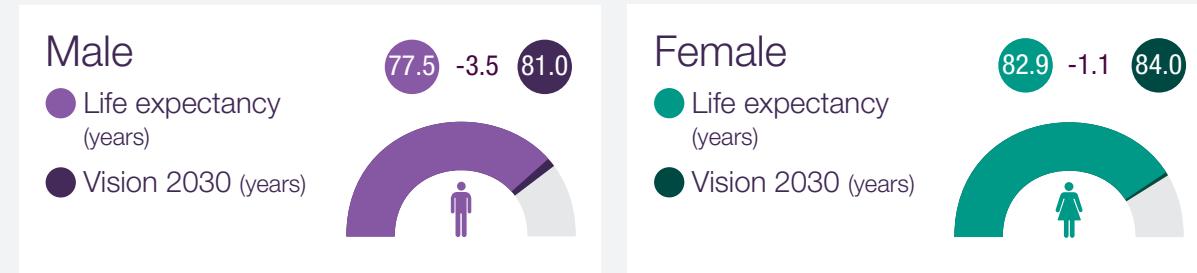
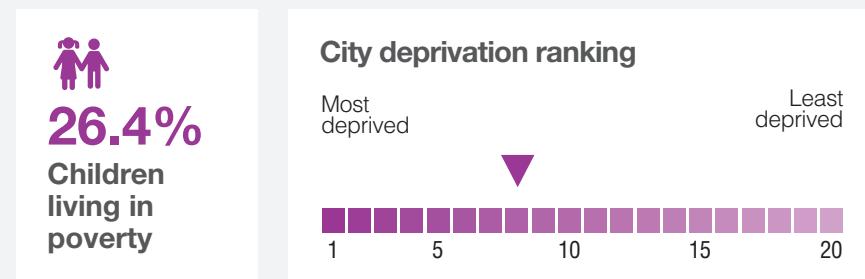
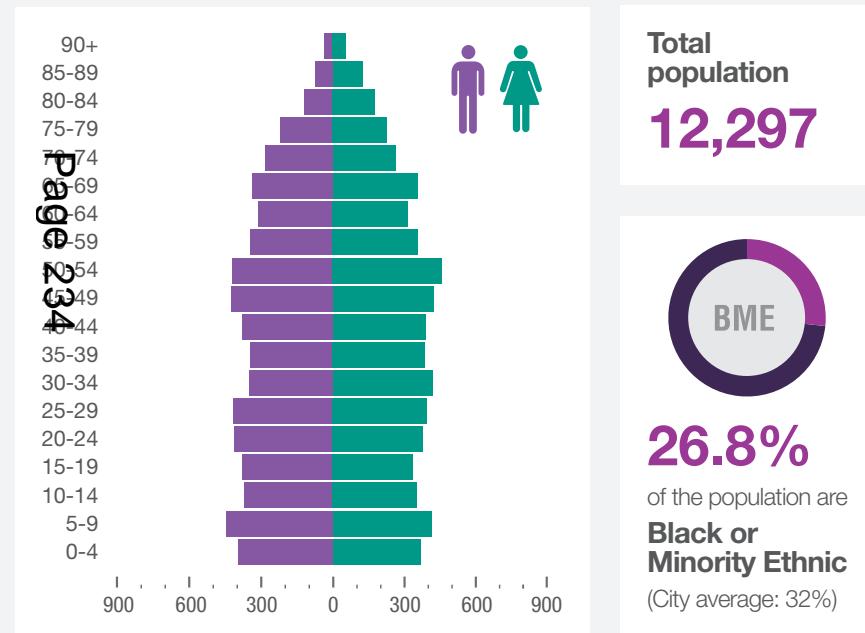
Key: Compared to city average Worse Similar Better

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13.4

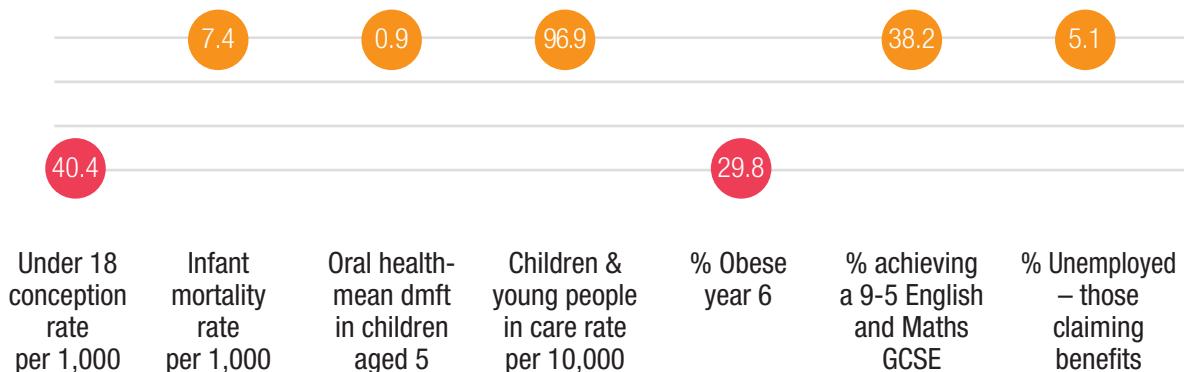
% of houses with 1 or more category 1 hazards identified	% Smoking prevalence	Rate per 100,000 diabetes prevalence	Rate per 100,000 alcohol specific admissions	% providing unpaid care provision	% with a limiting illness which limits daily activities a little or a lot	Rate per 100,000 dementia prevalence	Rate per 100,000 falls admissions 65+	Rate per 100,000 respiratory admissions 65+	% below average or very low wellbeing 65+	% Fuel poverty	Permanent placements in residential or nursing care rate per 100,000 65+
26.0	1511	336	10.6	28.5	186.0	2305	2106	14.6	11.5	773	



## Your ward at a glance: **Bilston North**

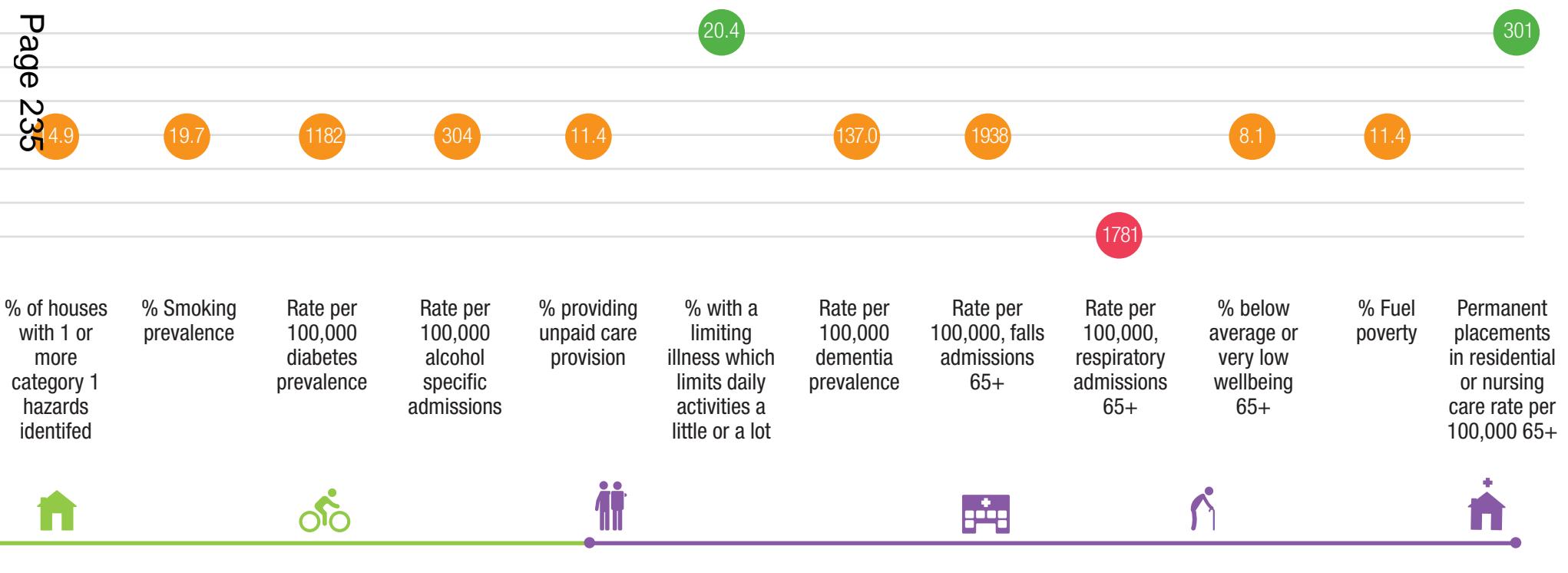


## What is life like in your ward?

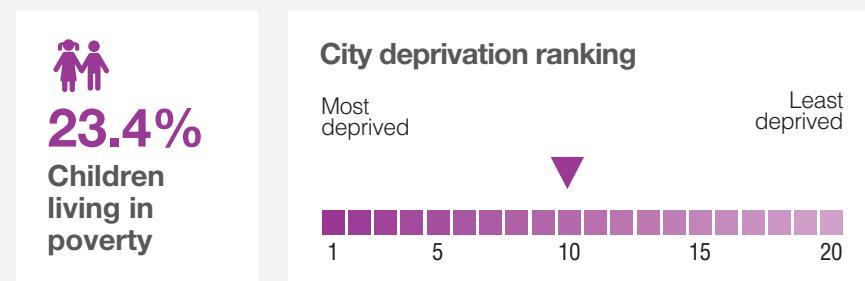
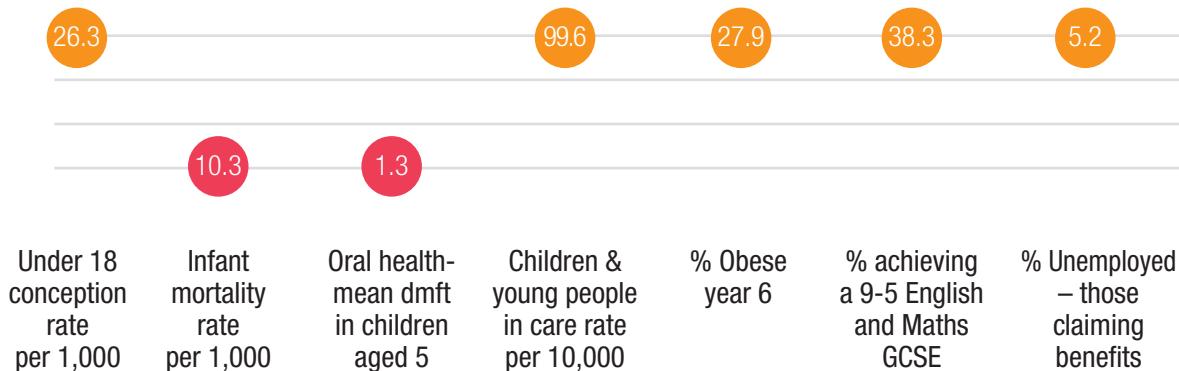
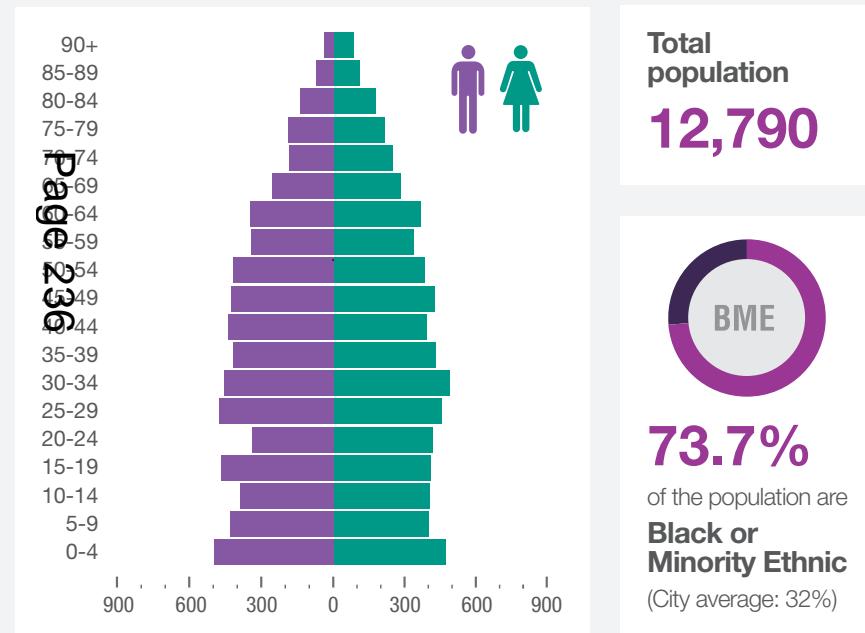




Key: Compared to city average Worse Similar Better



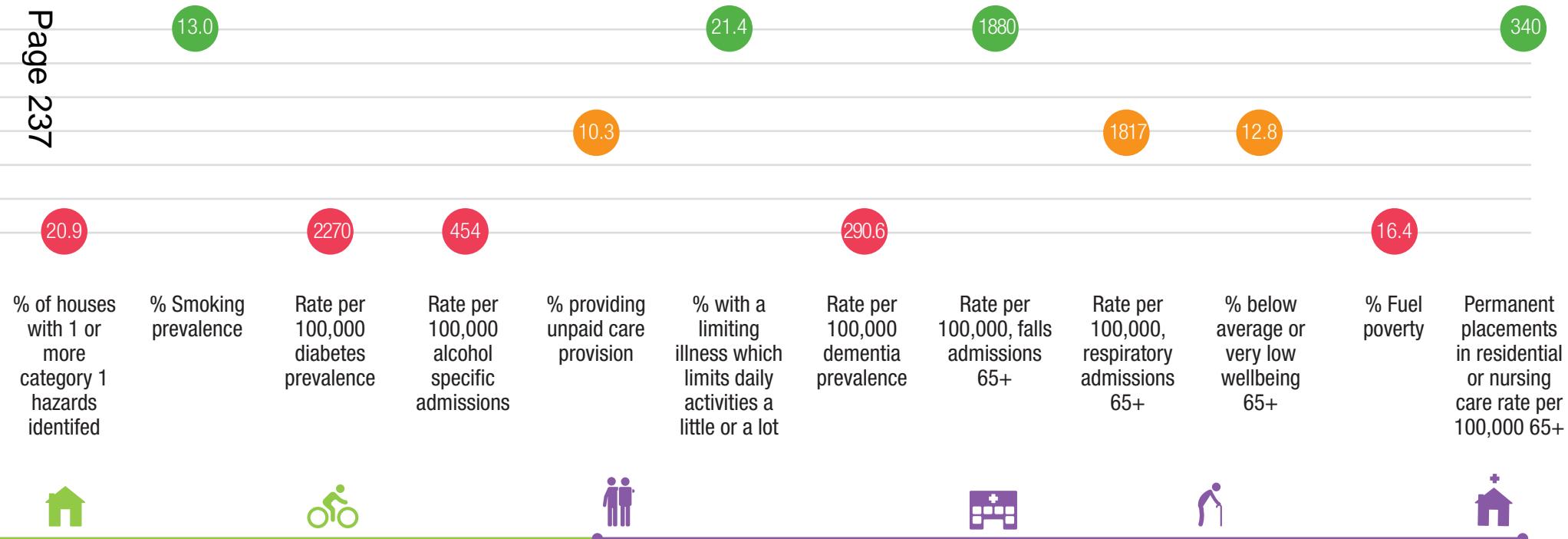
# Your ward at a glance: **Blakenhall**





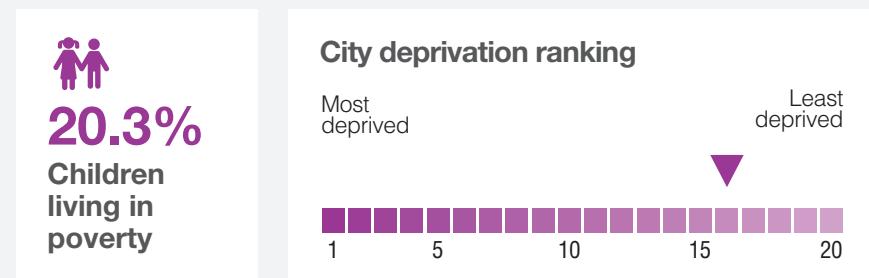
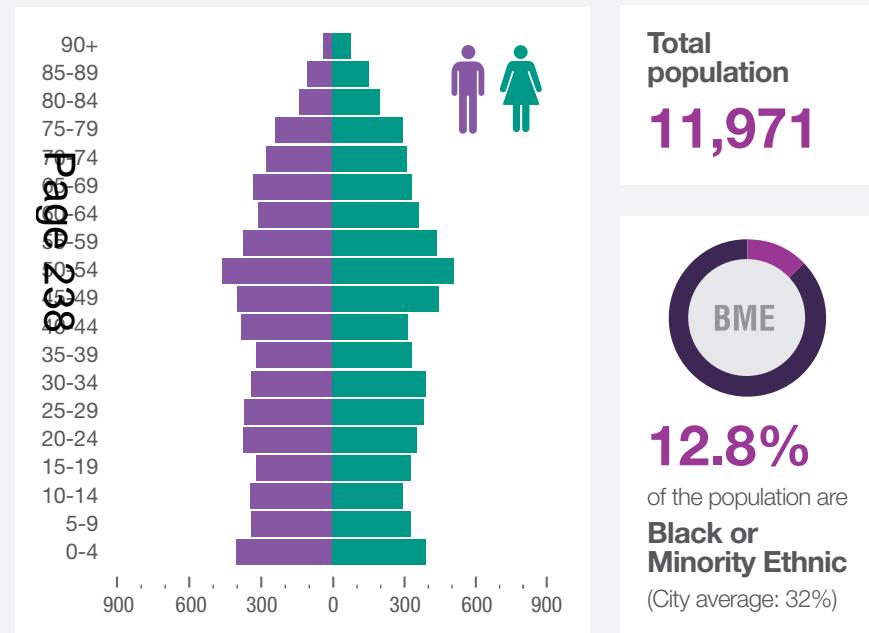
Key: Compared to city average  Worse  Similar  Better

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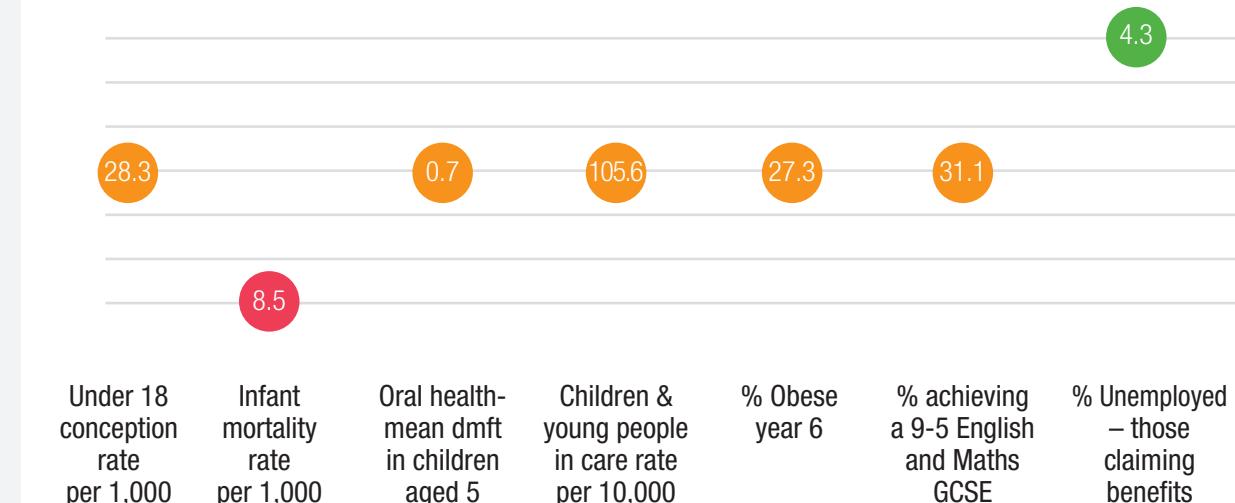


Your ward at a glance:

# Bushbury North



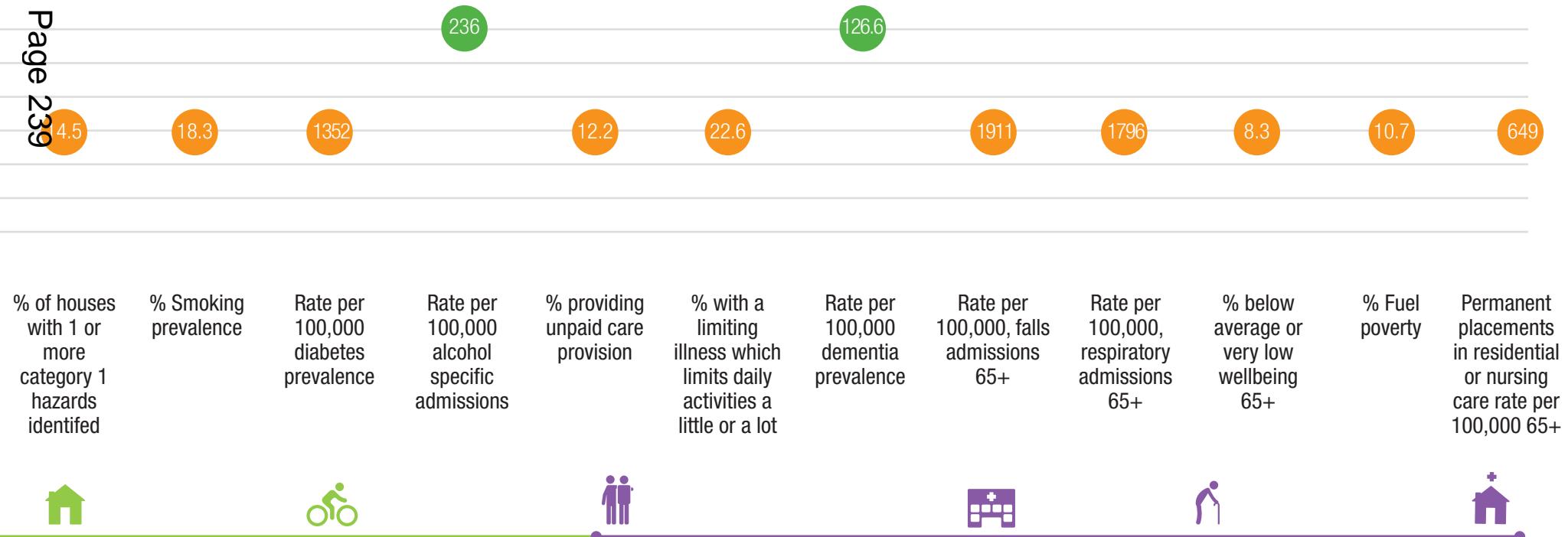
## What is life like in your ward?





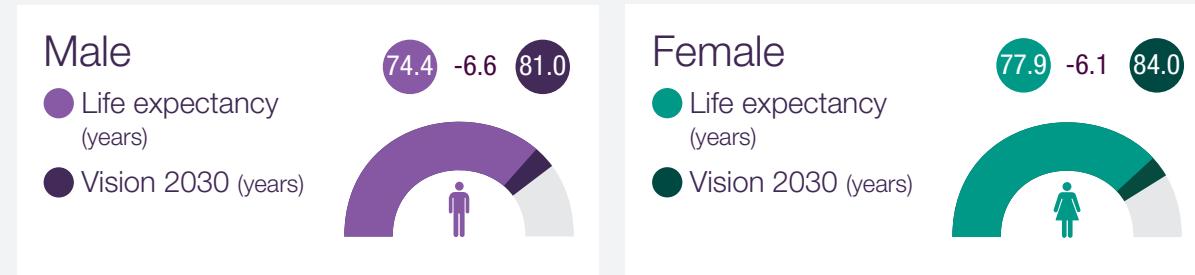
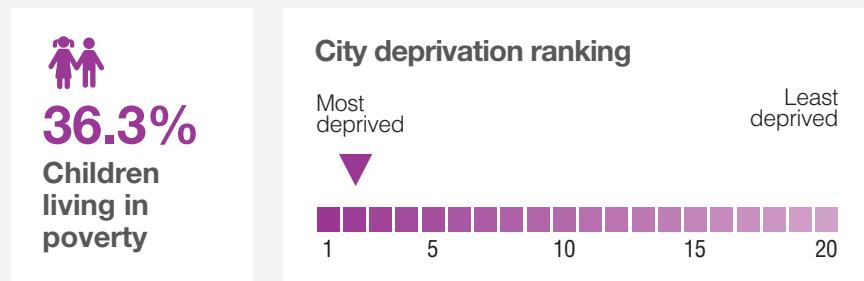
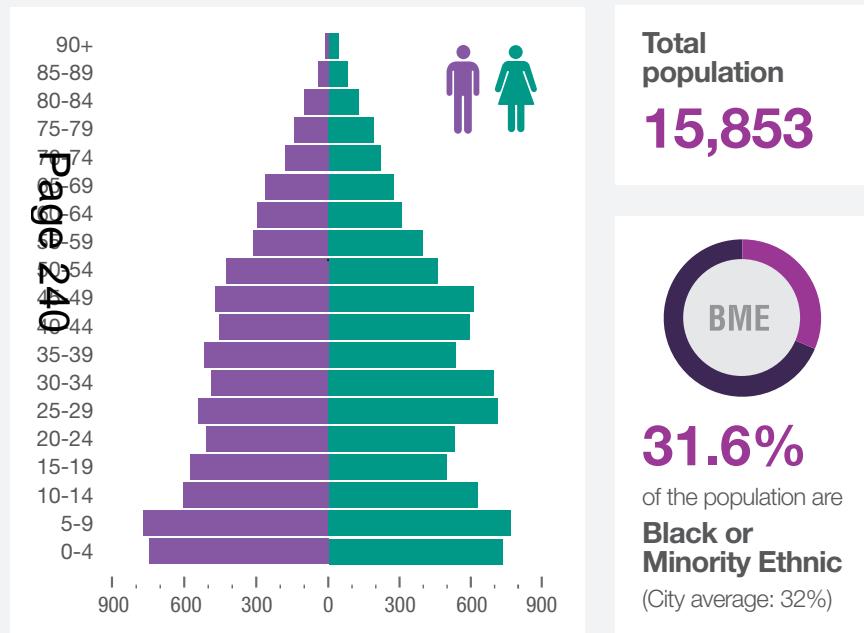
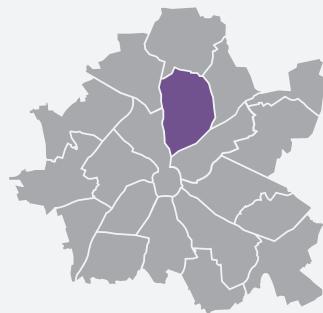
Key: Compared to city average ● Worse ● Similar ● Better

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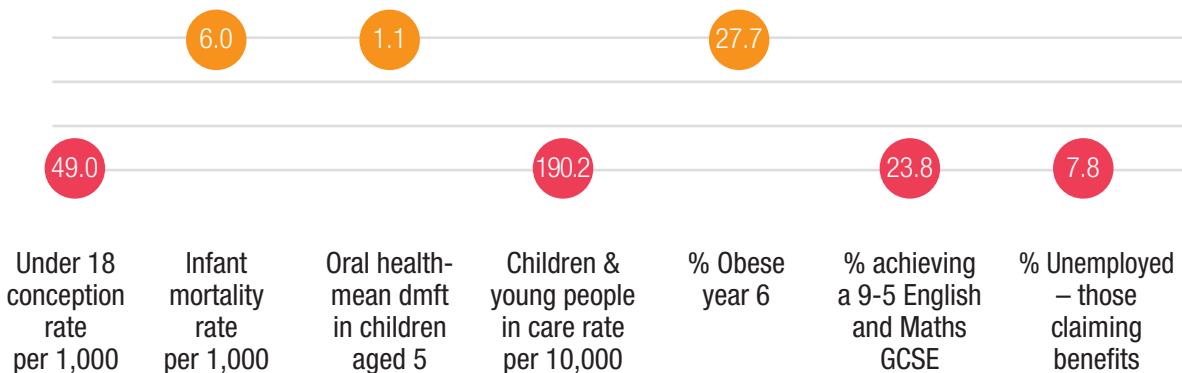


## Your ward at a glance:

# Bushbury South and Low Hill



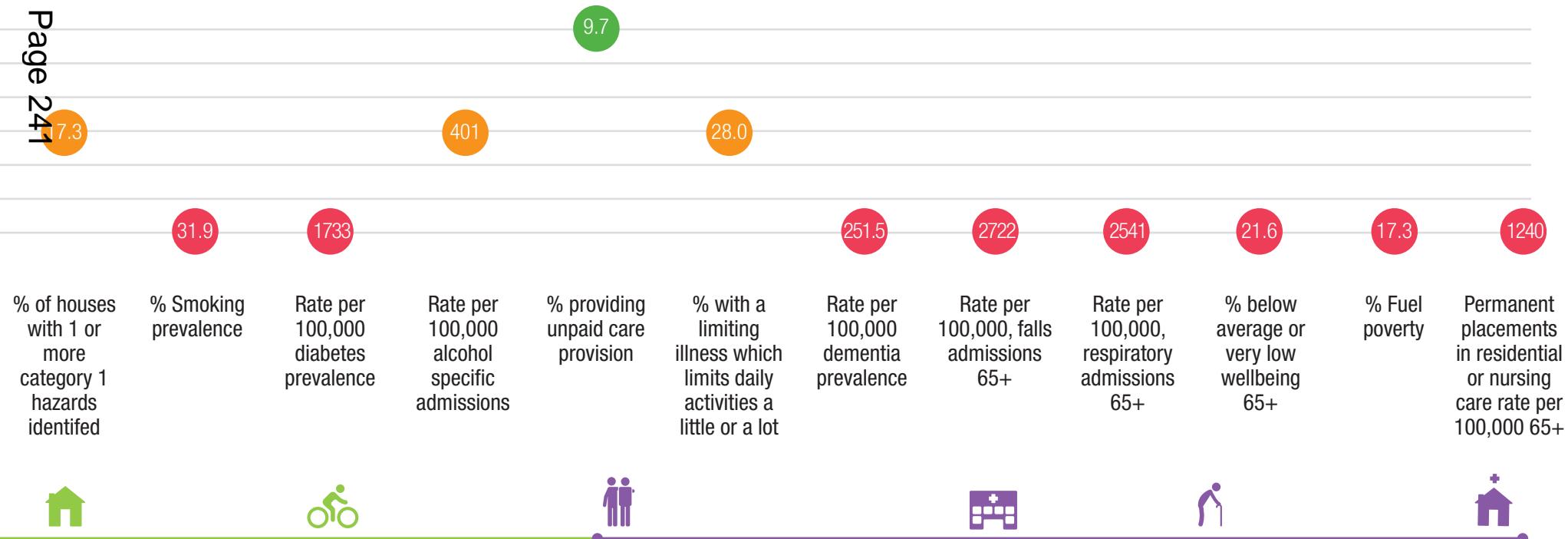
## What is life like in your ward?



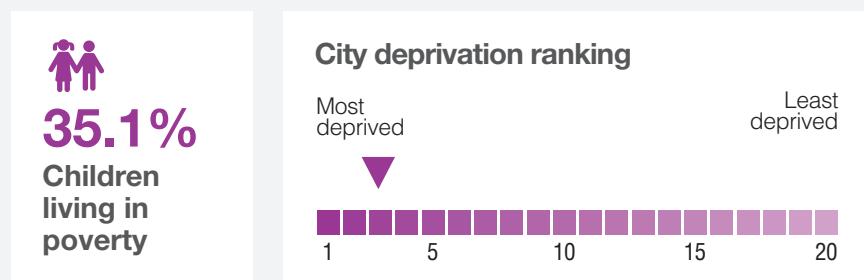
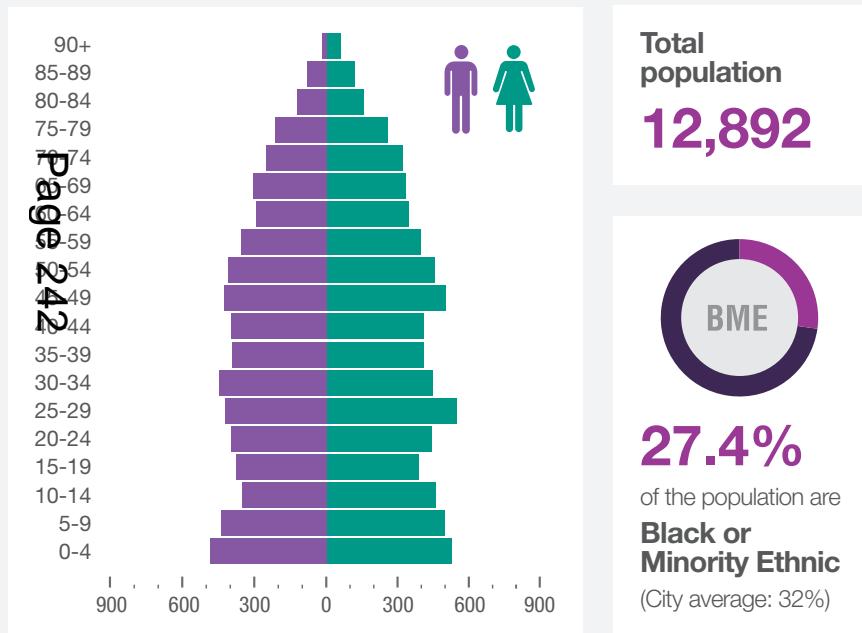
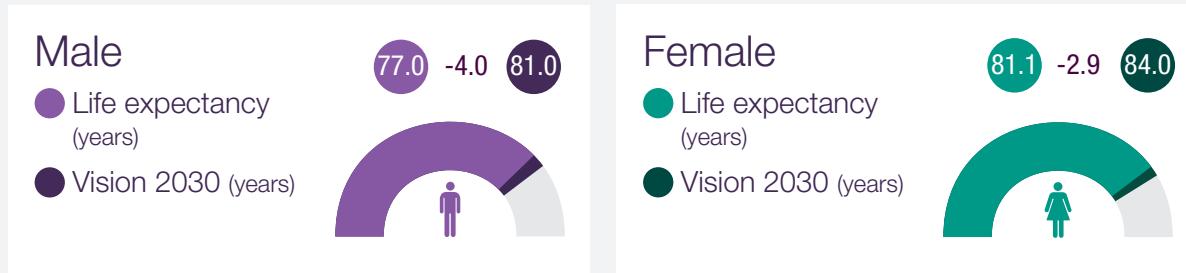


Key: Compared to city average ● Worse ● Similar ● Better

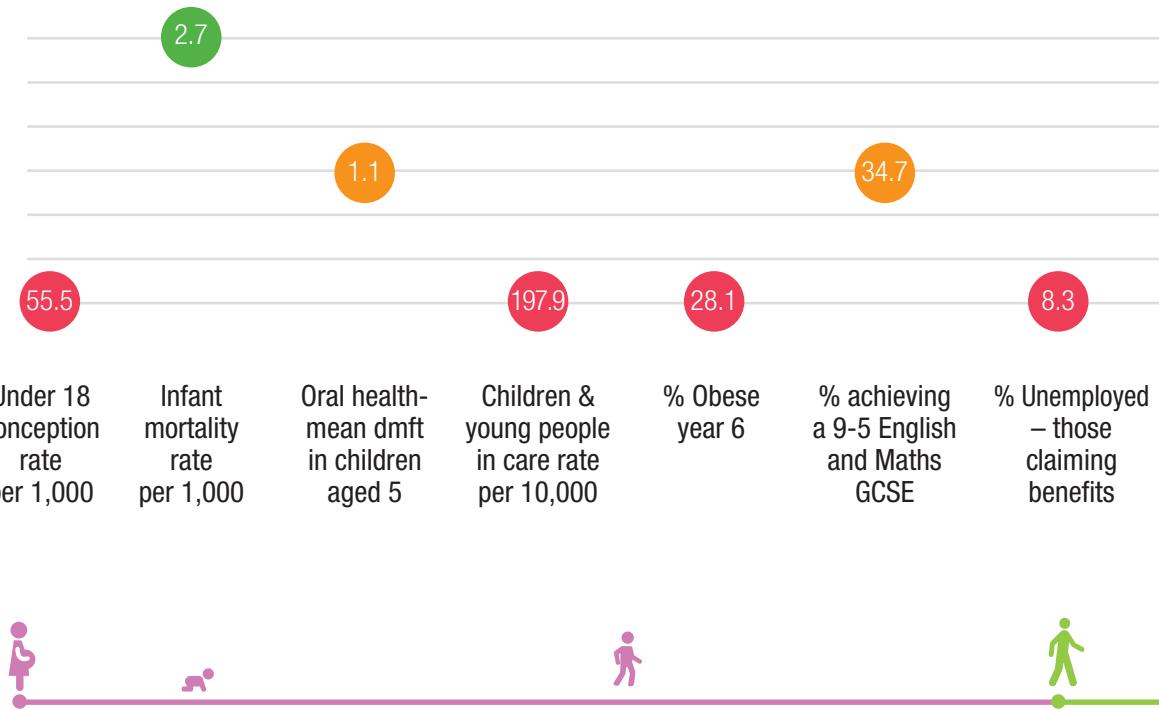
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## Your ward at a glance: **East Park**



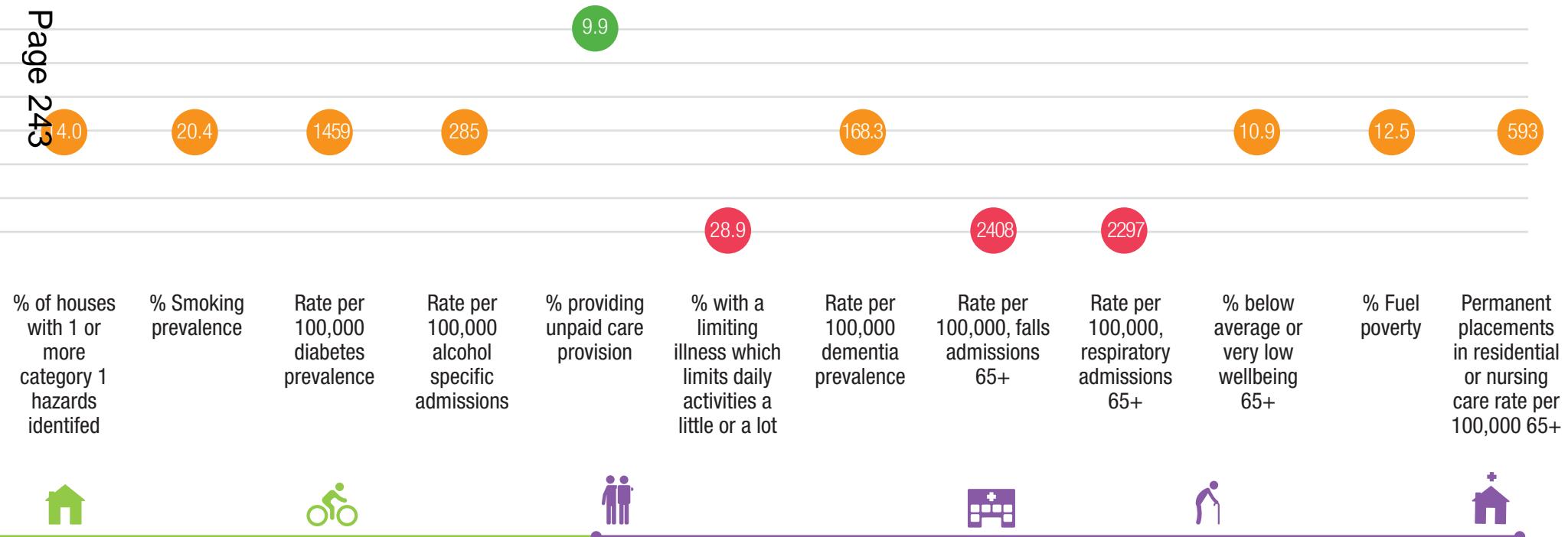
## What is life like in your ward?



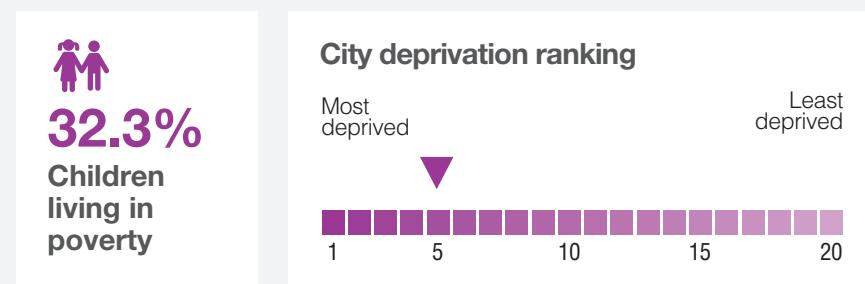
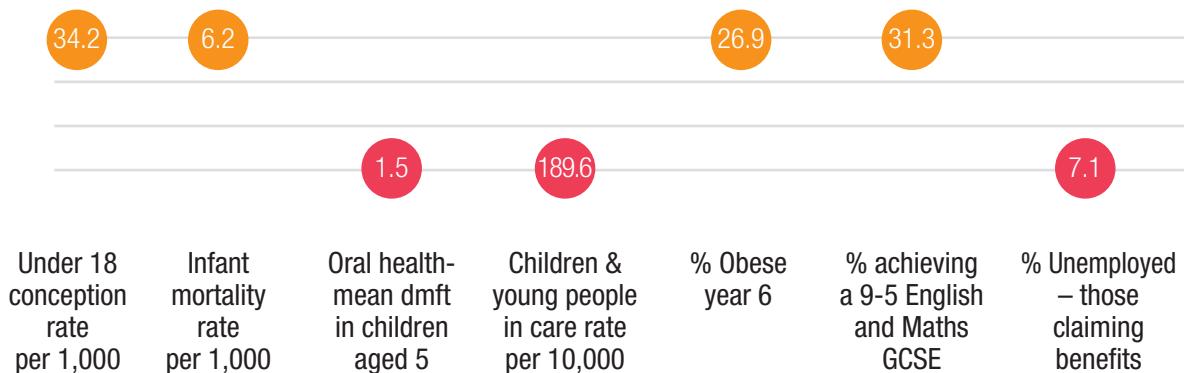
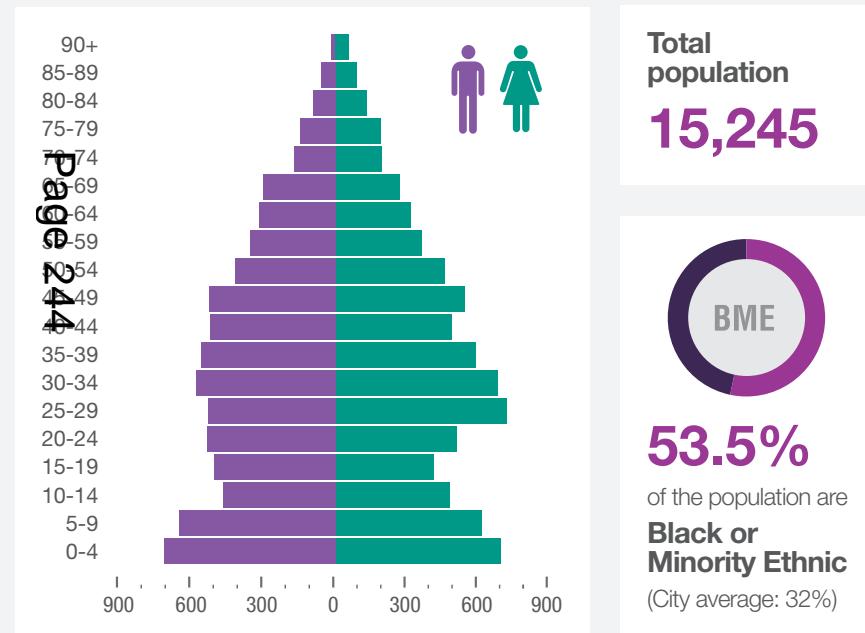
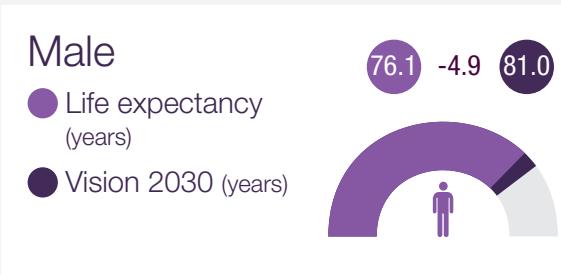


Key: Compared to city average ● Worse ● Similar ● Better

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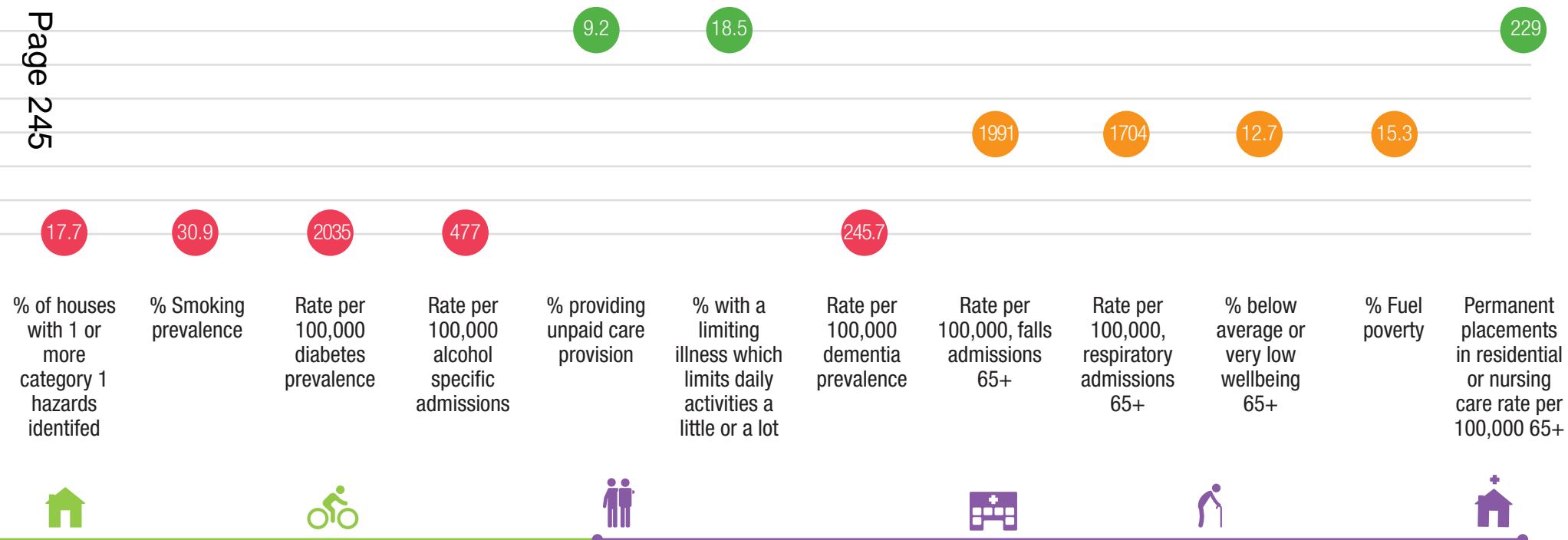
## Your ward at a glance: **Ettingshall**



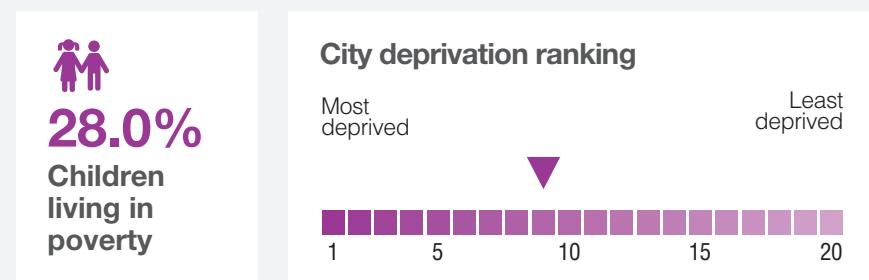
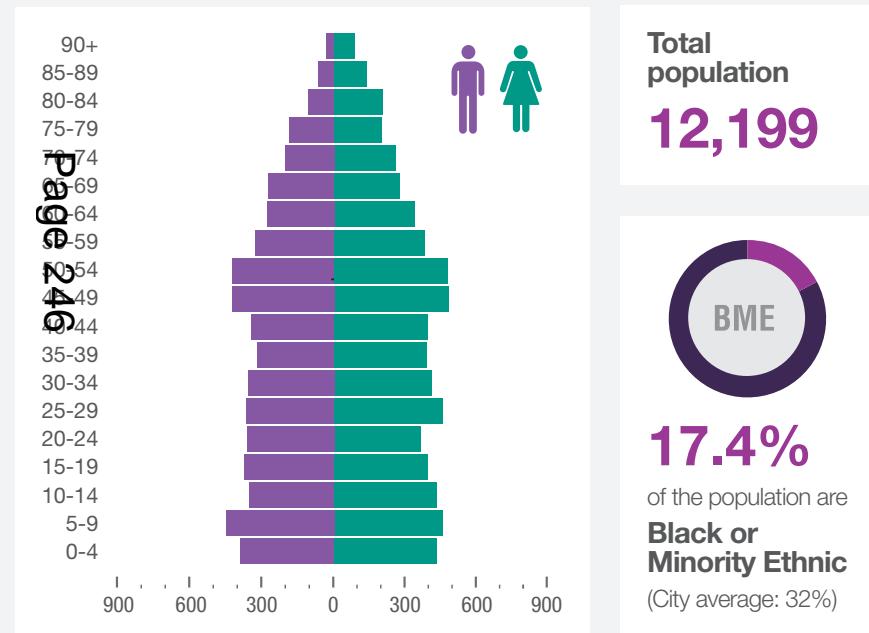


Key: Compared to city average ● Worse ● Similar ● Better

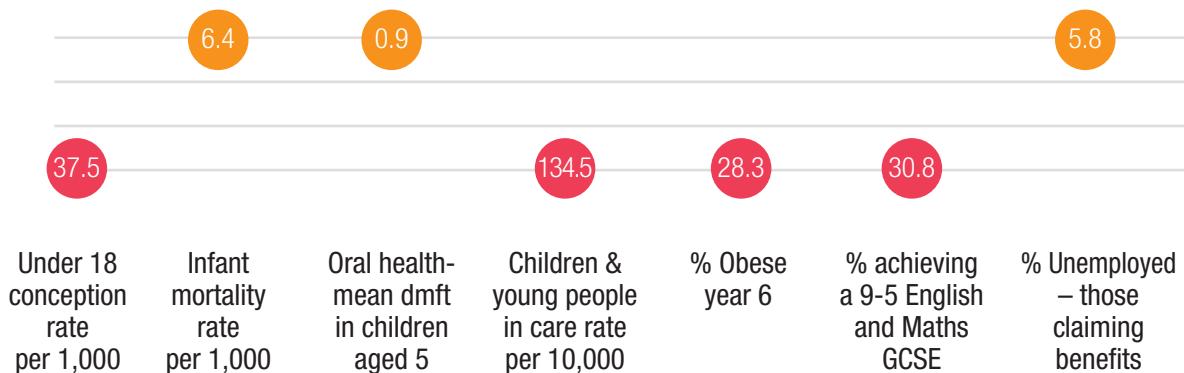
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## Your ward at a glance: **Fallings Park**

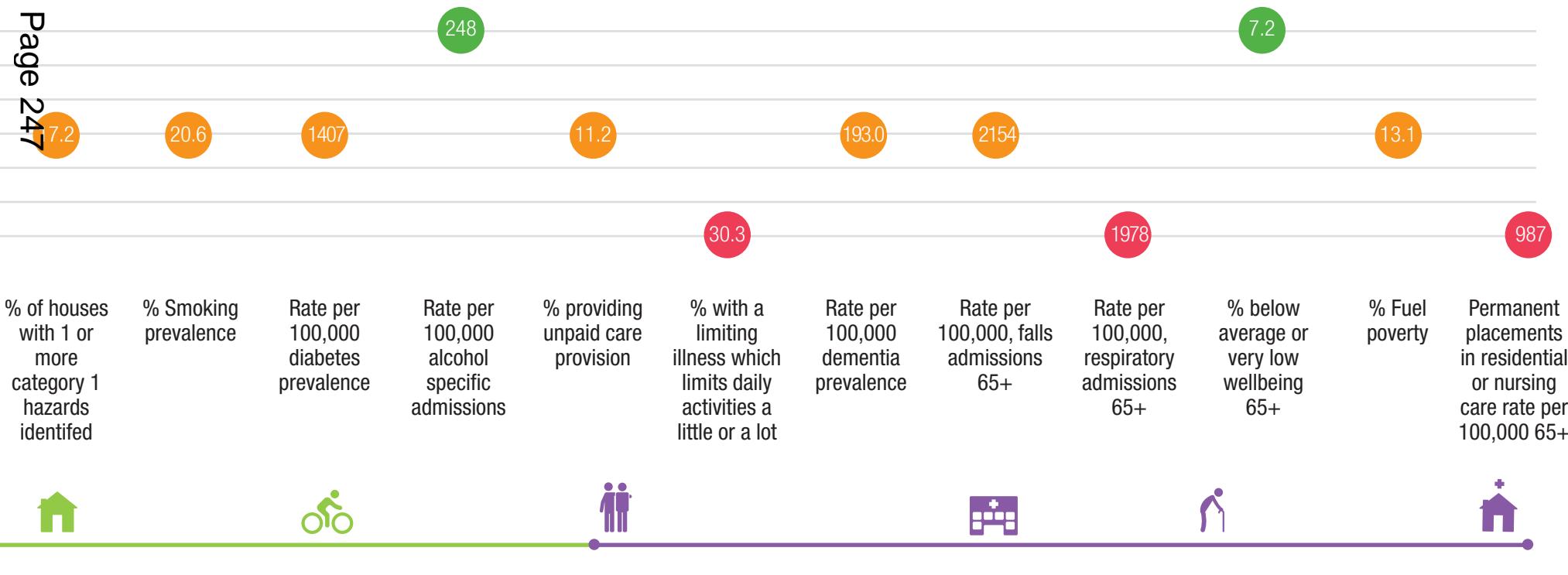


## What is life like in your ward?

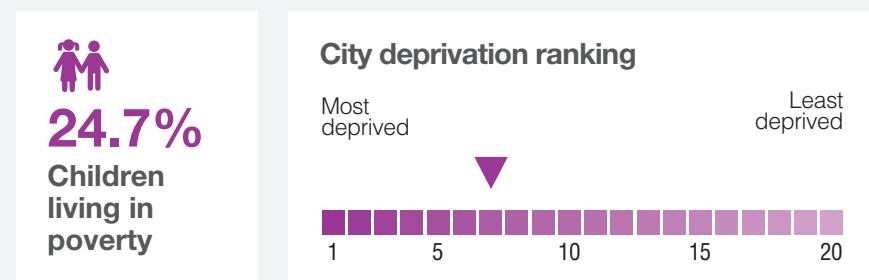
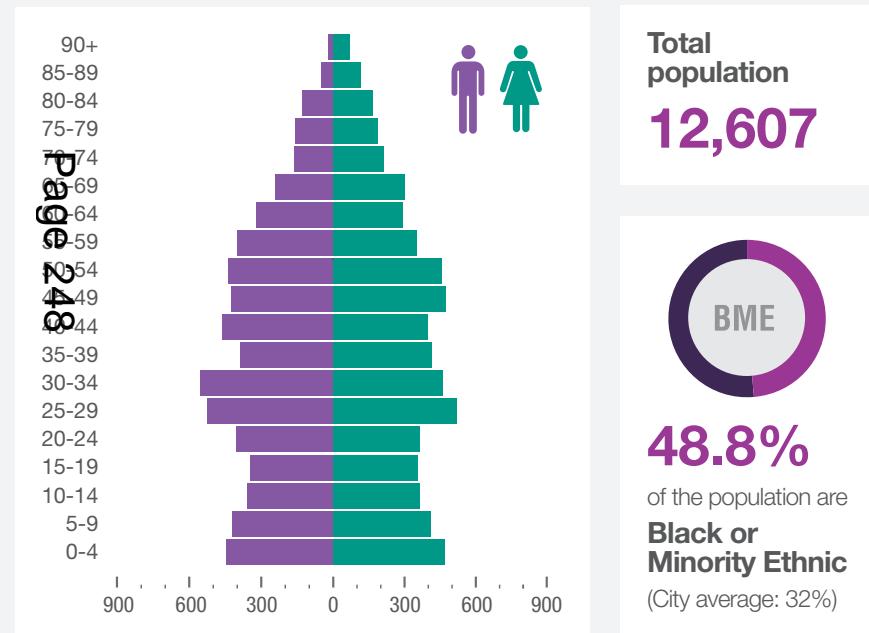
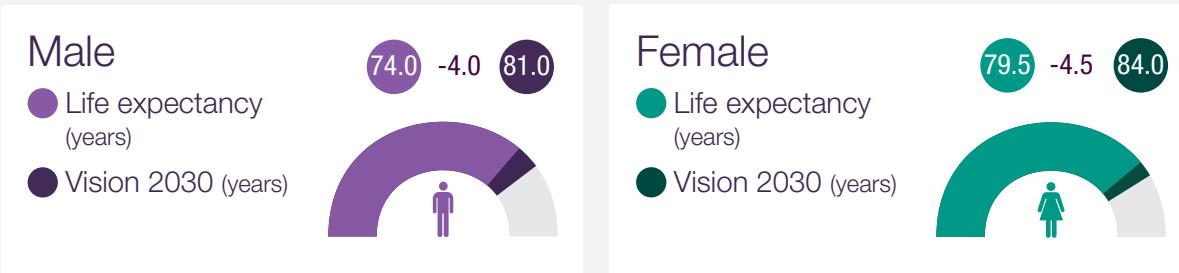
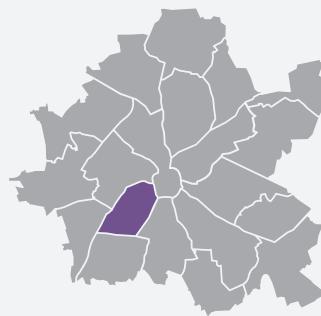




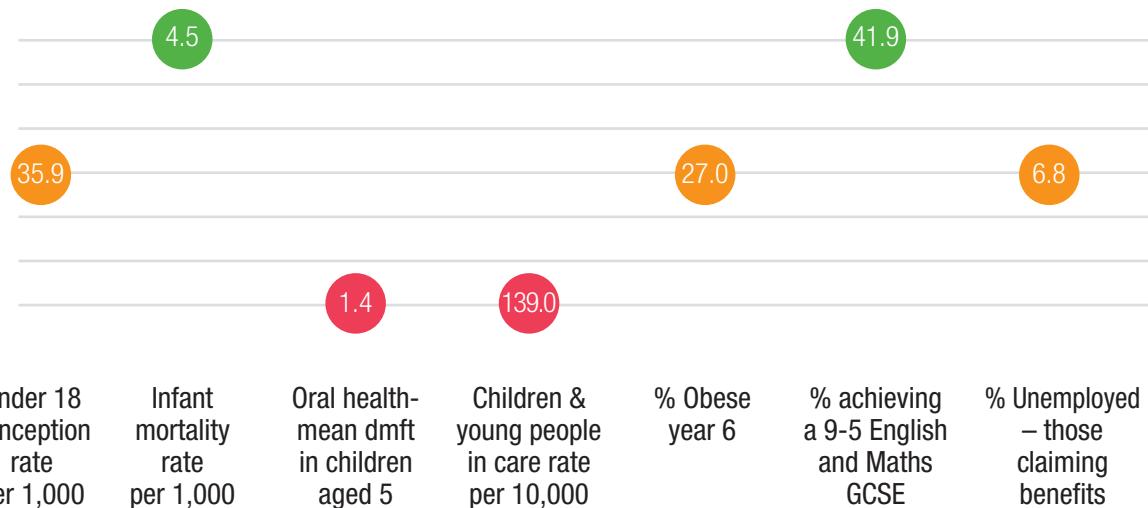
Key: Compared to city average Worse Similar Better



## Your ward at a glance: **Graiseley**



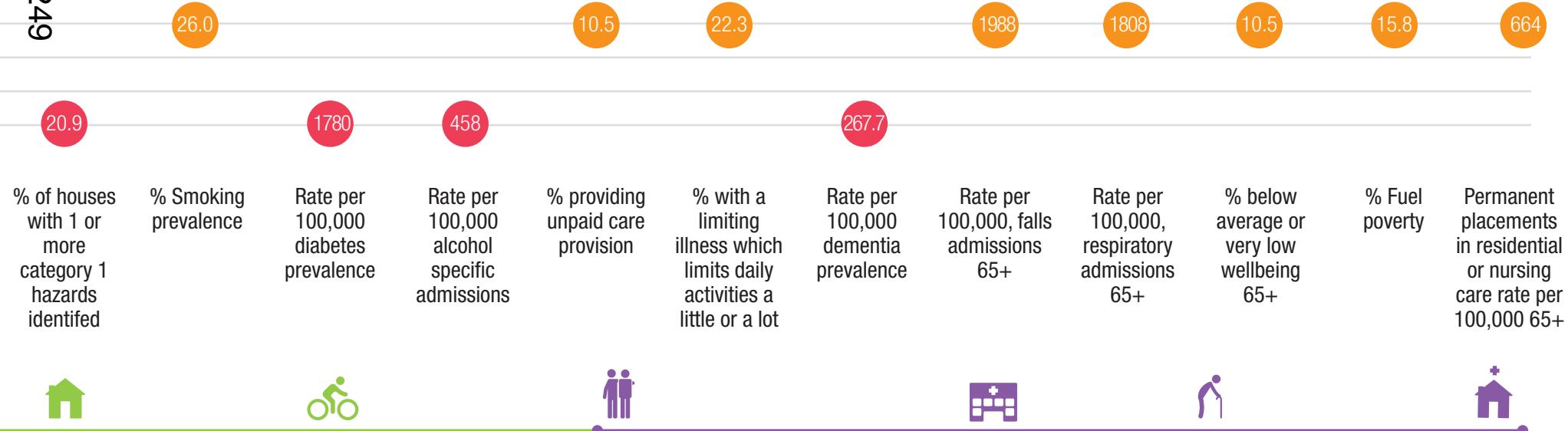
# What is life like in your ward?



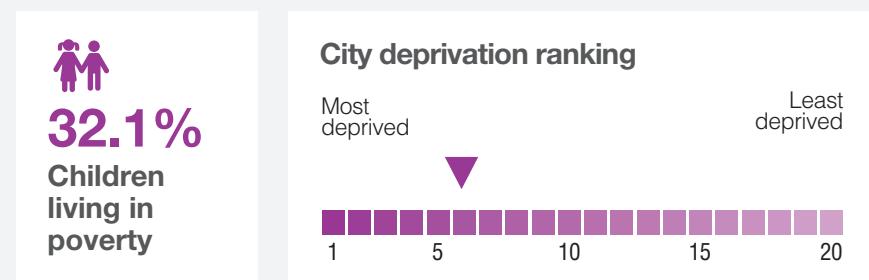
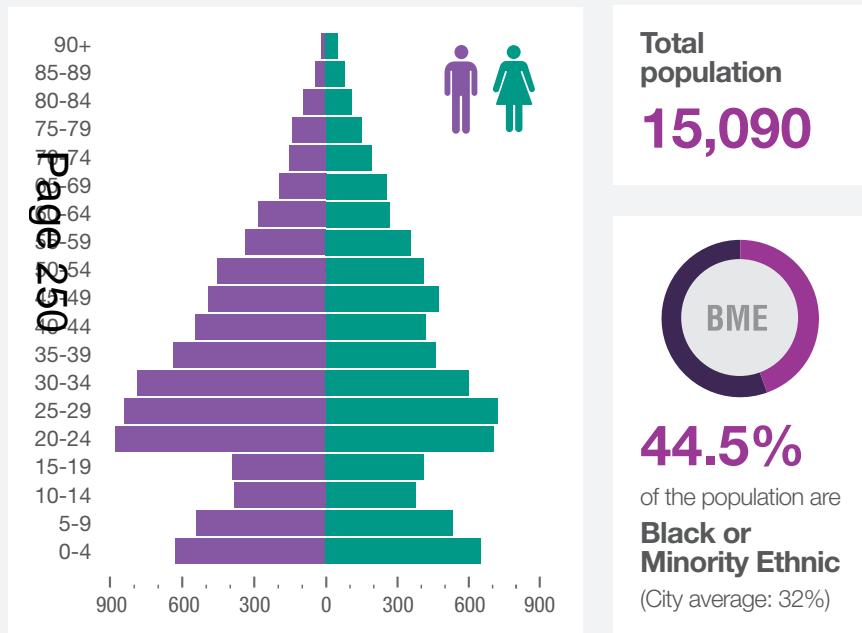
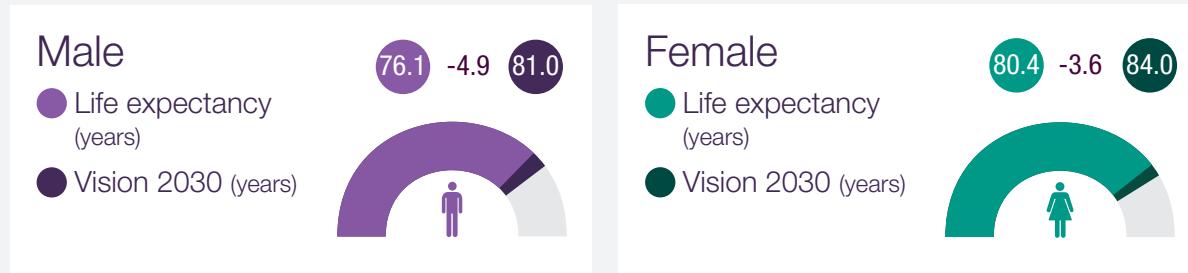


Key: Compared to city average    ● Worse    ○ Similar    ● Better

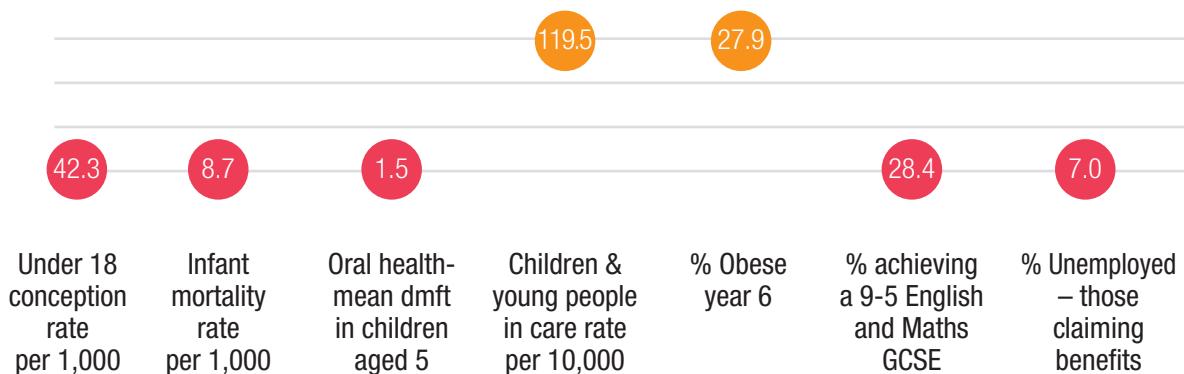
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## Your ward at a glance: **Heath Town**

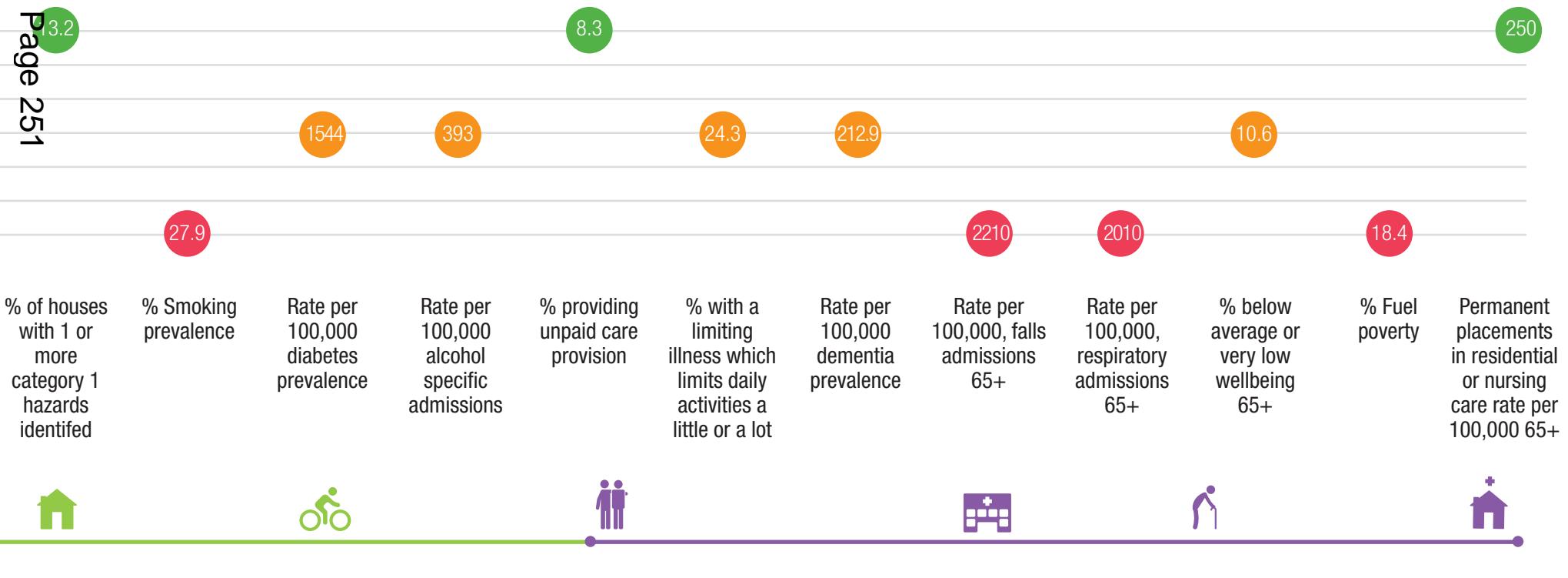


# What is life like in your ward?

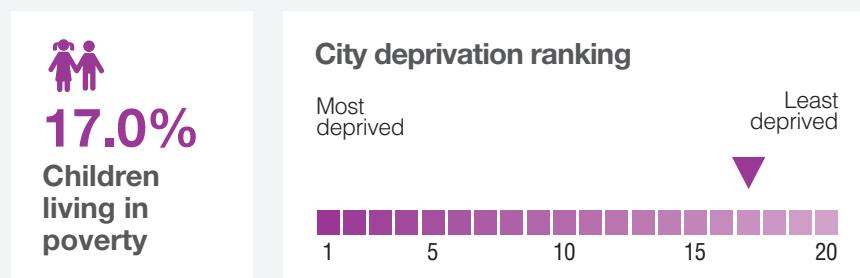
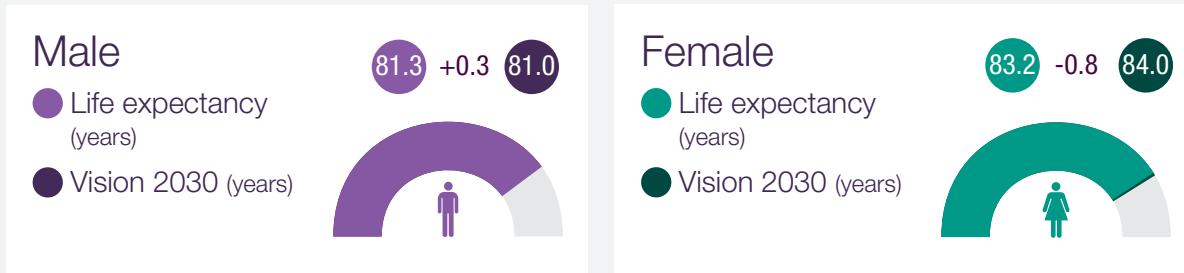




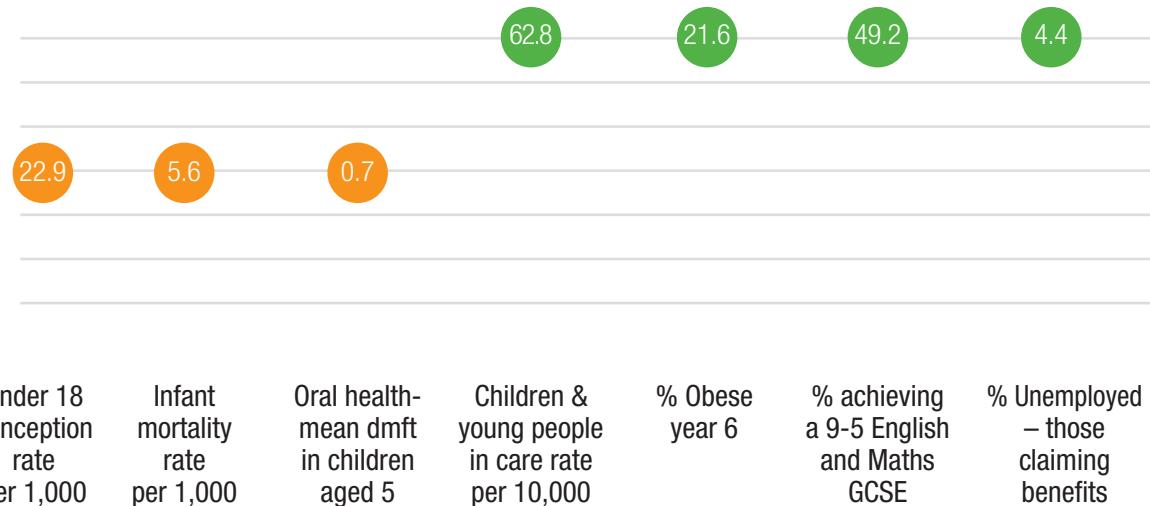
Key: Compared to city average ● Worse ● Similar ● Better



## Your ward at a glance: **Merry Hill**

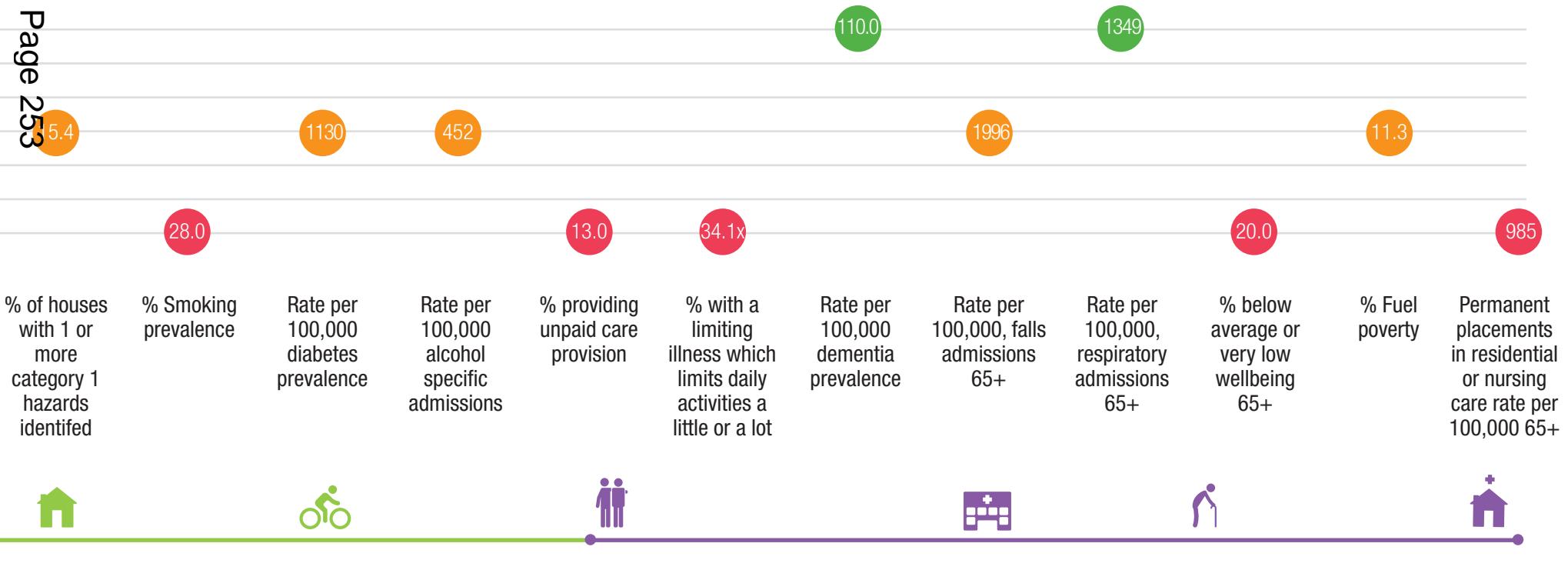


# What is life like in your ward?

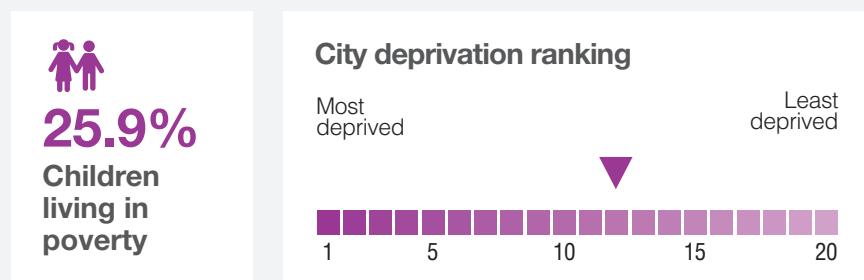
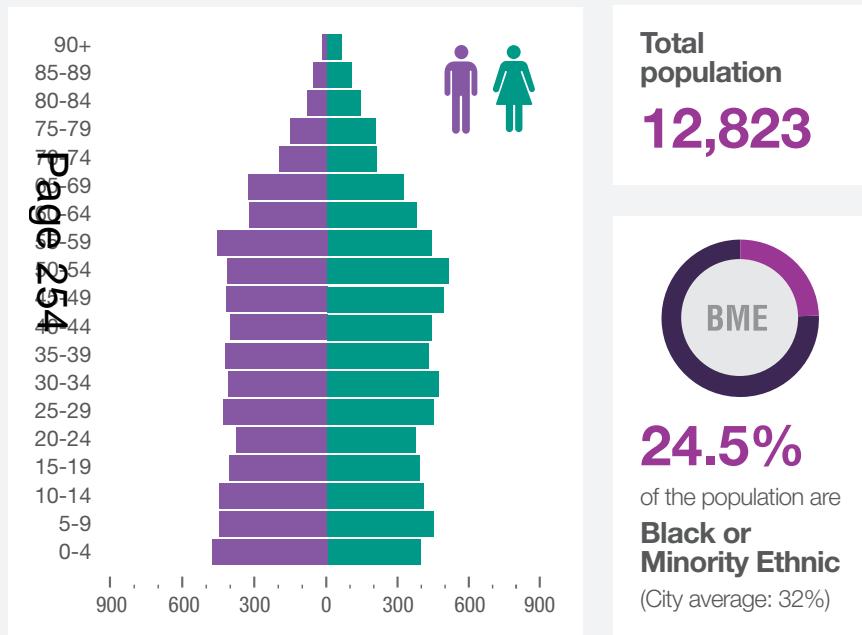
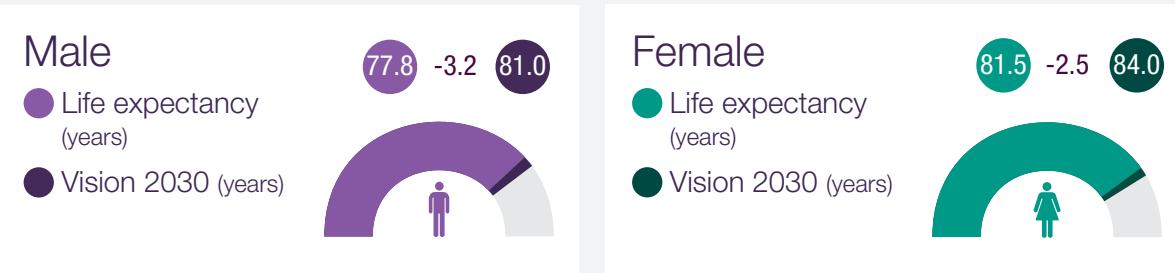
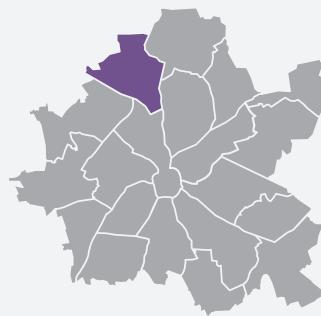




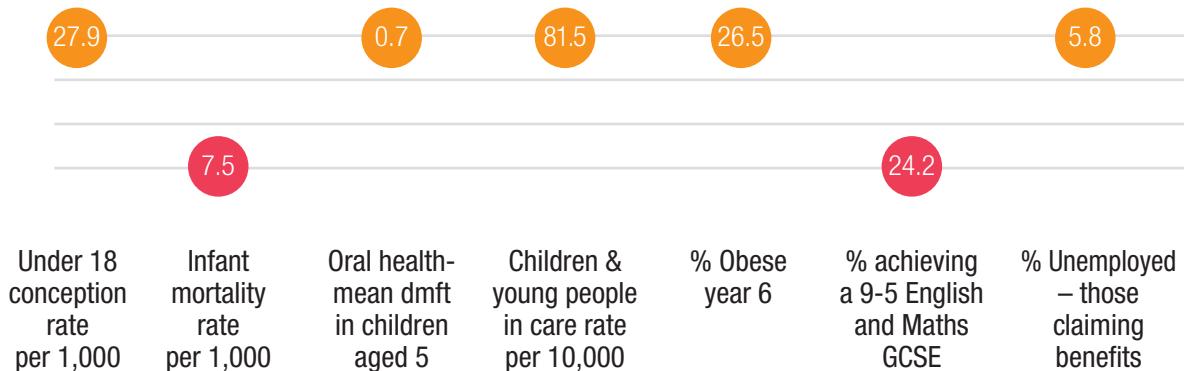
Key: Compared to city average ● Worse ● Similar ● Better



## Your ward at a glance: **Oxley**

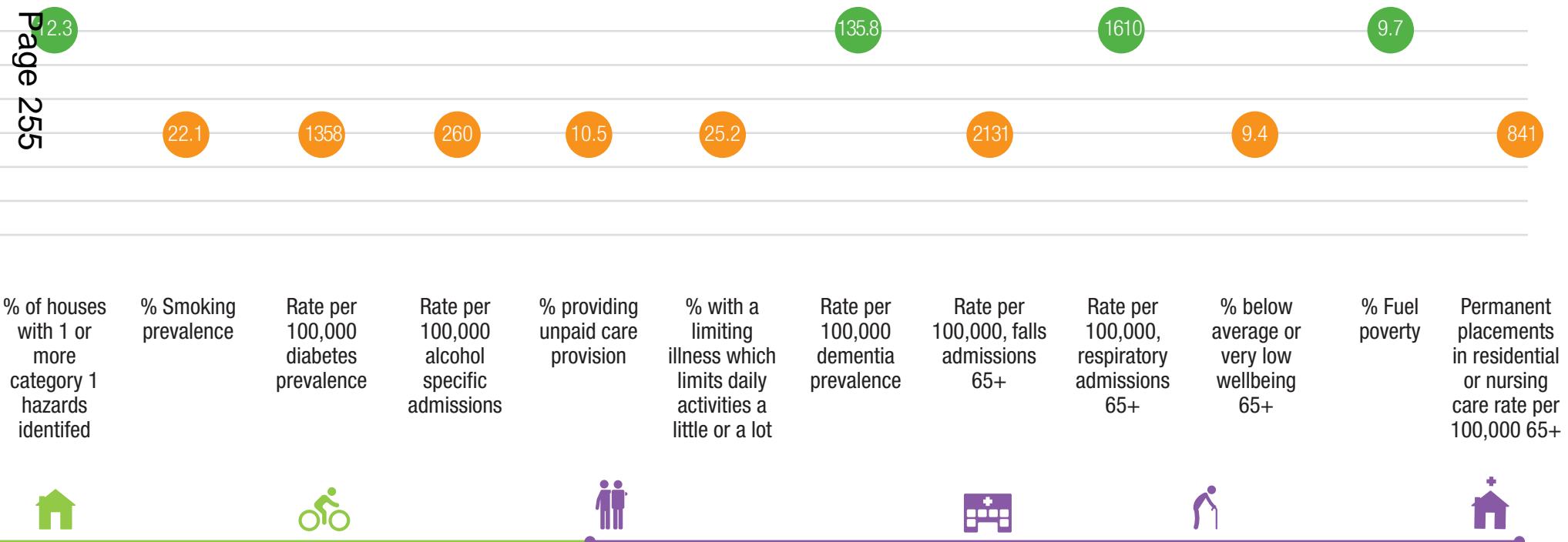


## What is life like in your ward?

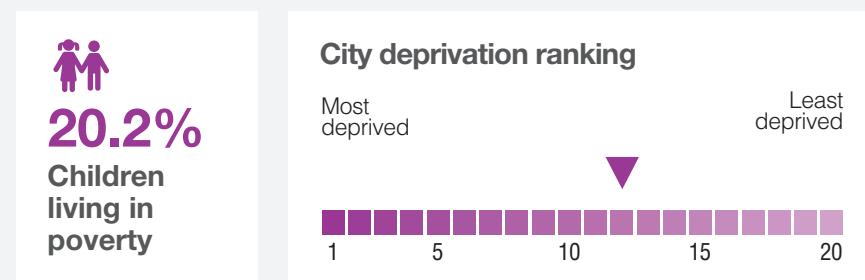
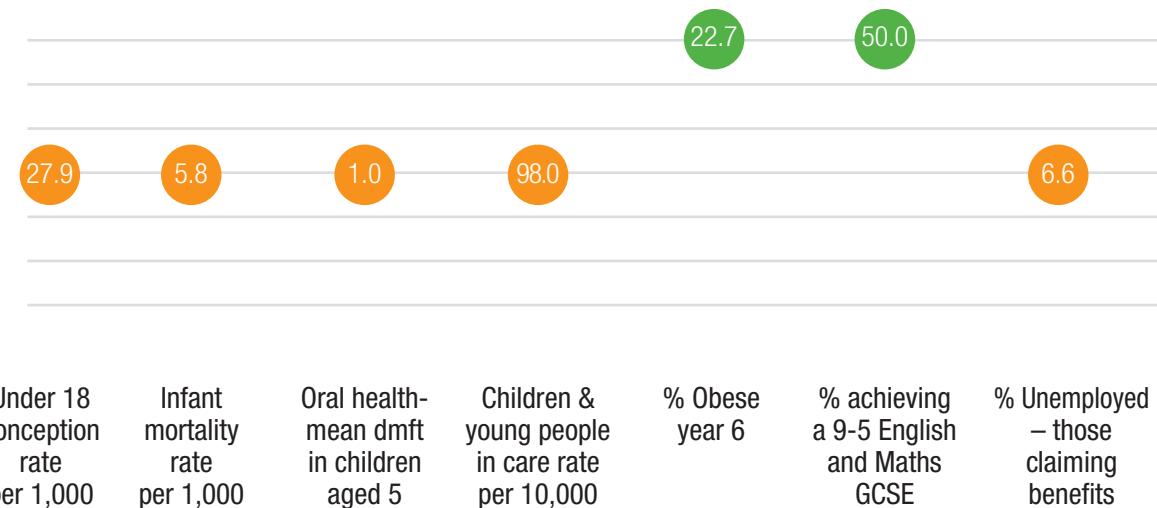
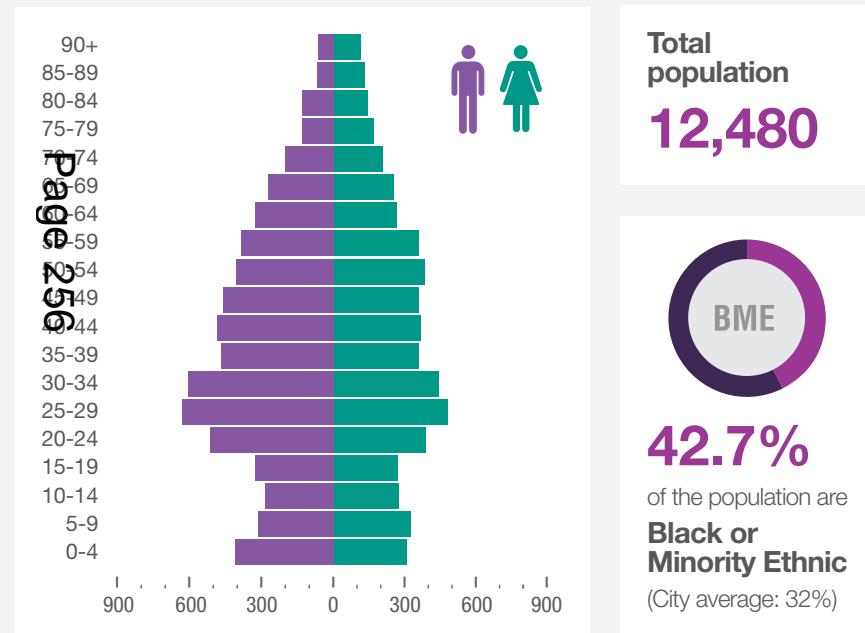
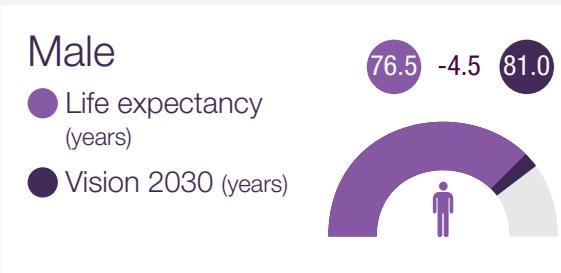




Key: Compared to city average    ● Worse    ○ Similar    ● Better

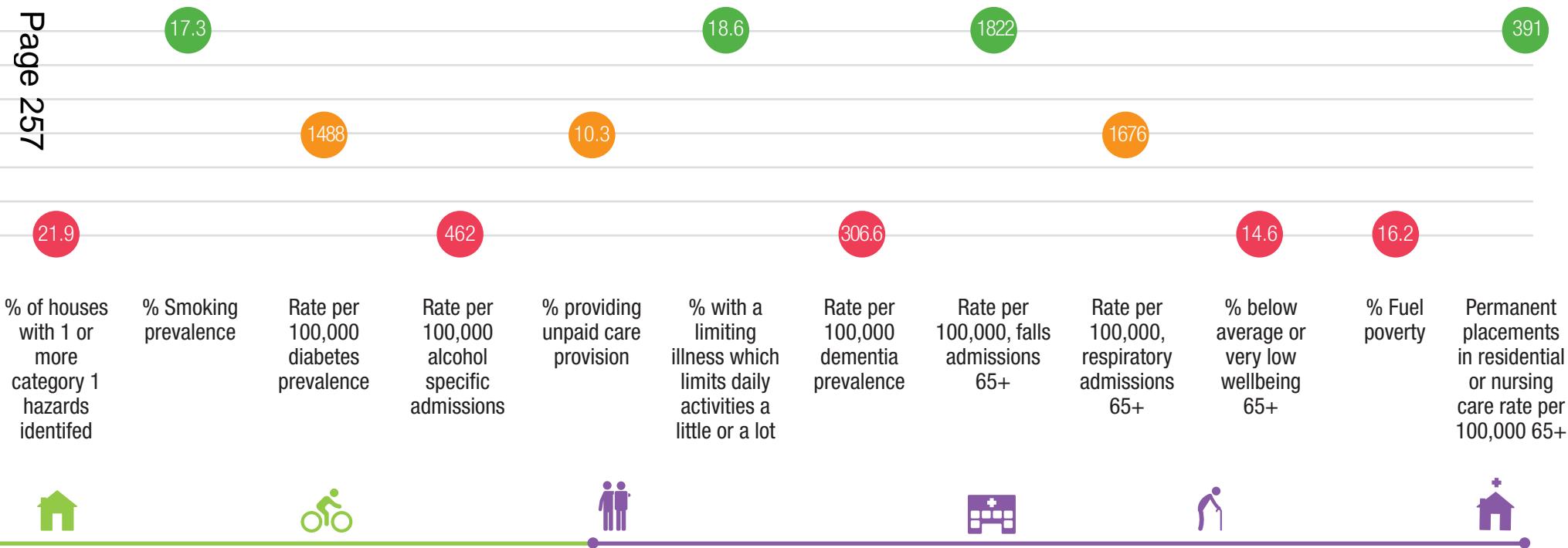


## Your ward at a glance: **Park**

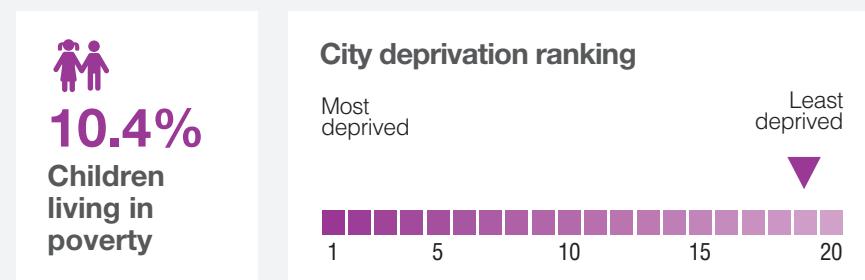
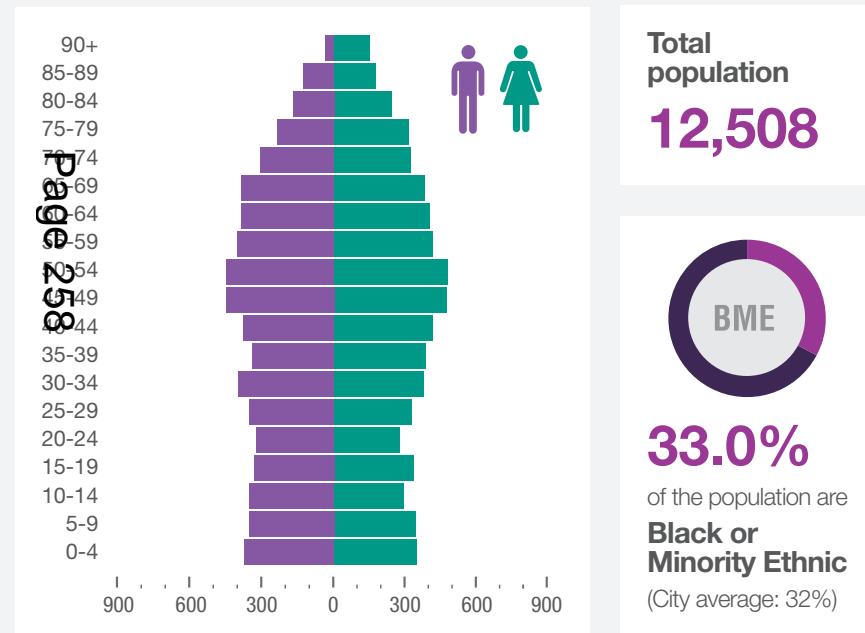
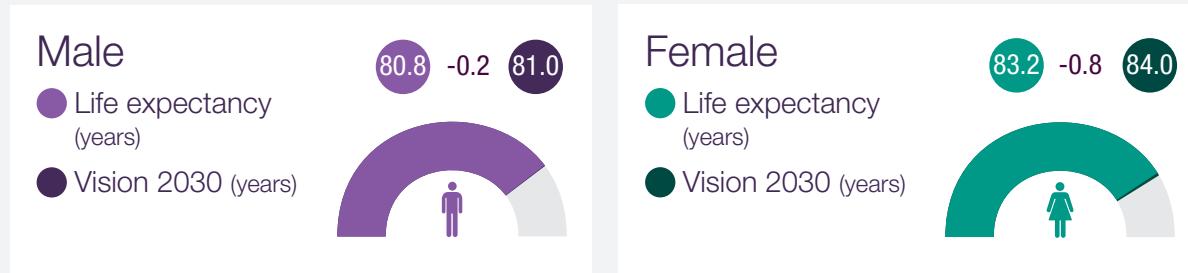




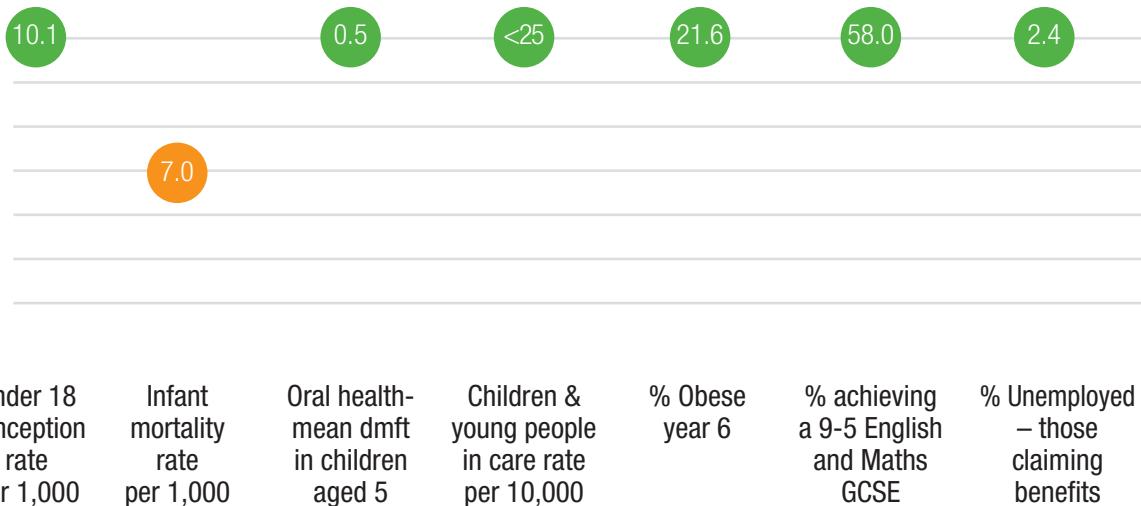
Key: Compared to city average ● Worse ● Similar ● Better



## Your ward at a glance: **Penn**



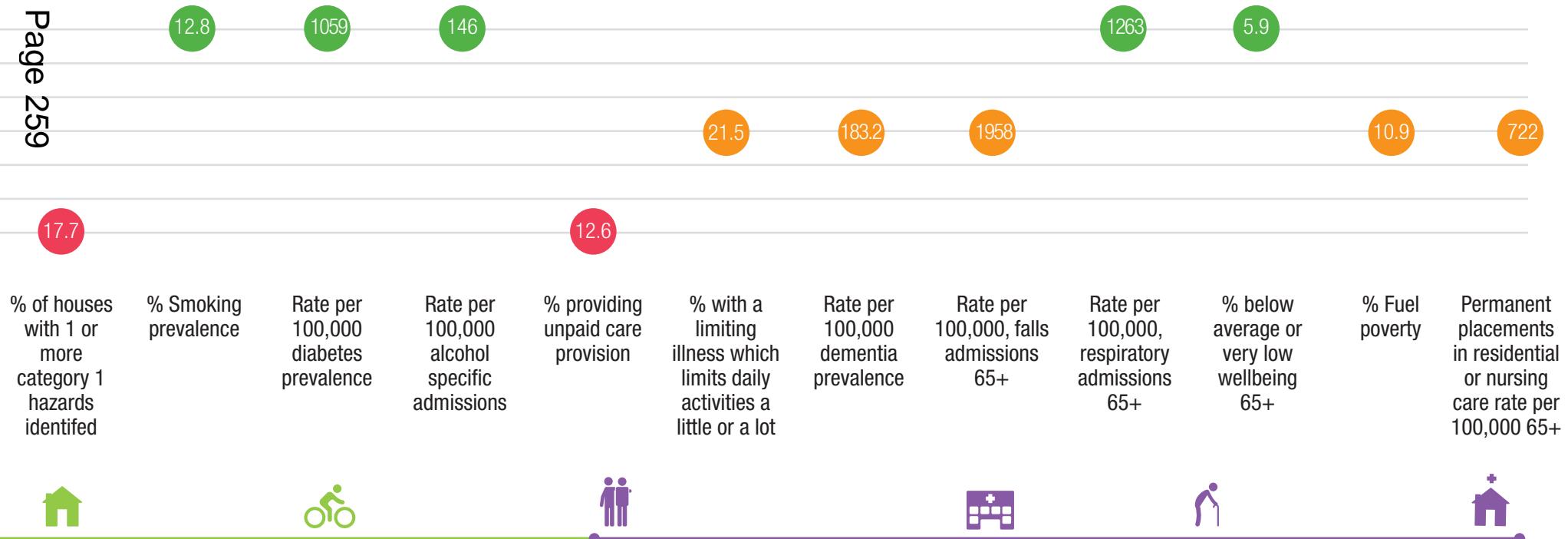
## What is life like in your ward?



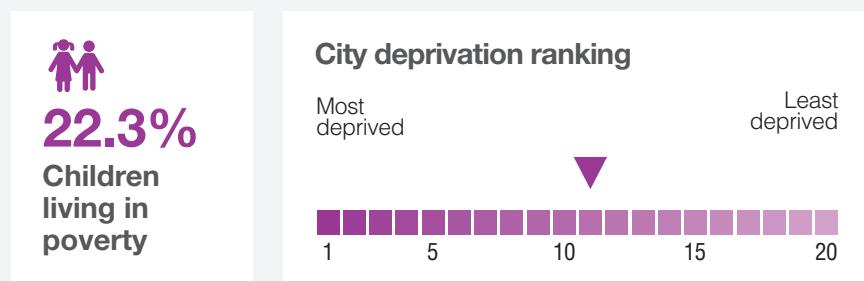
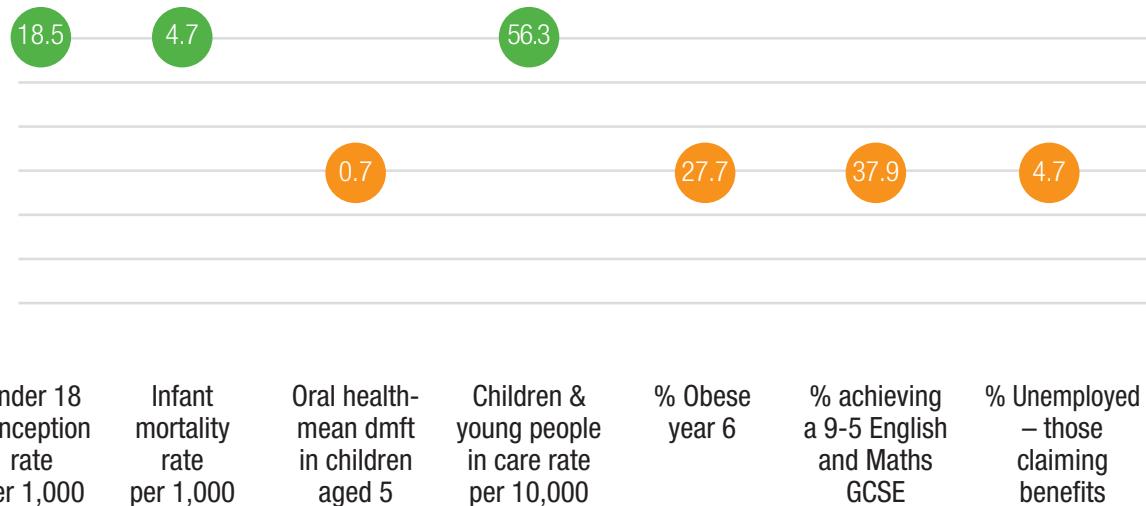
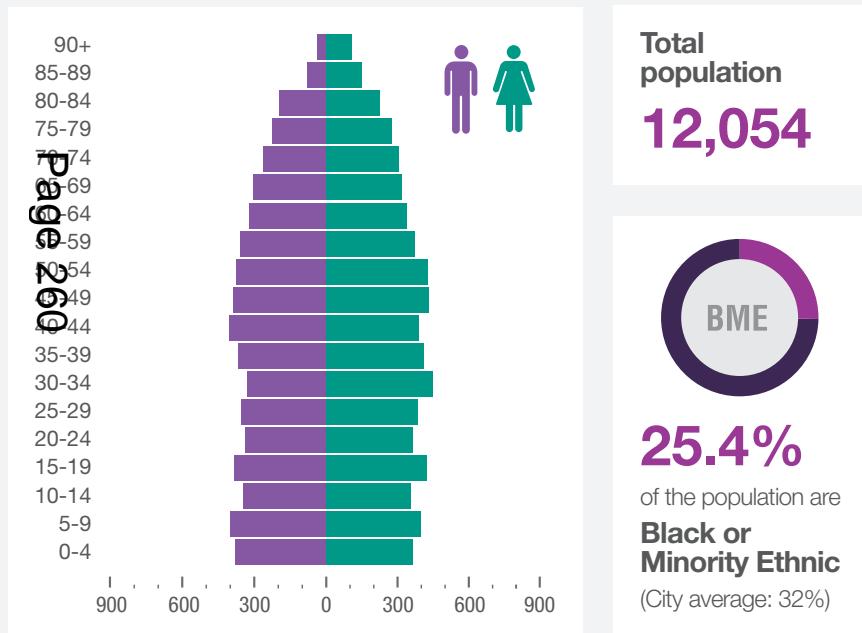
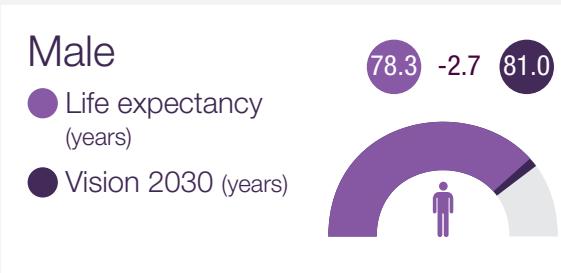


Key: Compared to city average    ● Worse    ○ Similar    ● Better

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## Your ward at a glance: **Spring Vale**





Key: Compared to city average ● Worse ● Similar ● Better

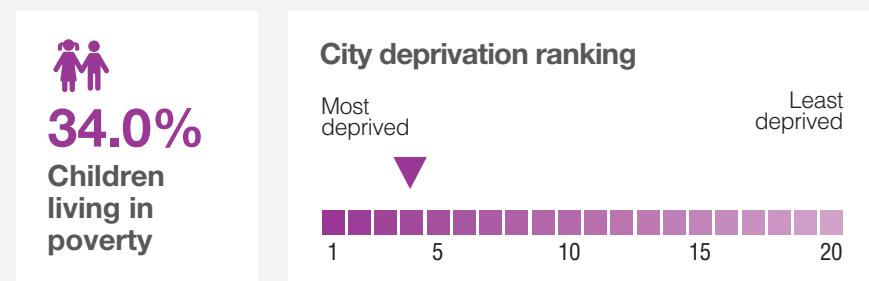
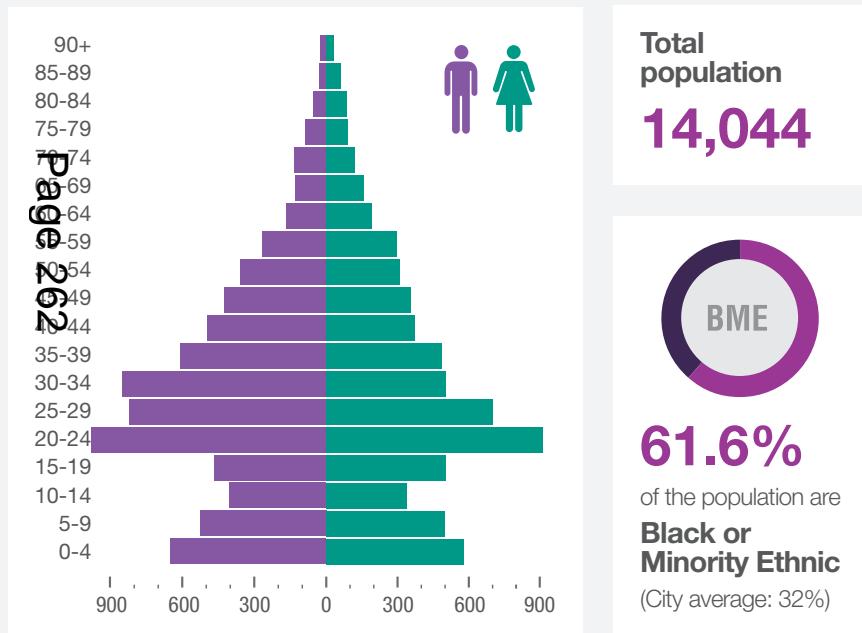
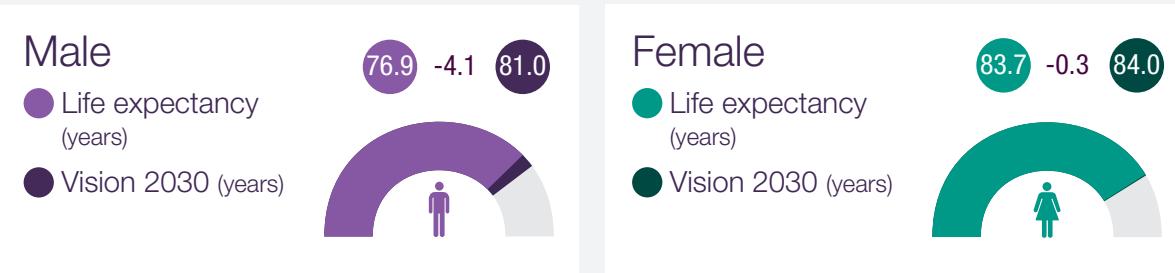
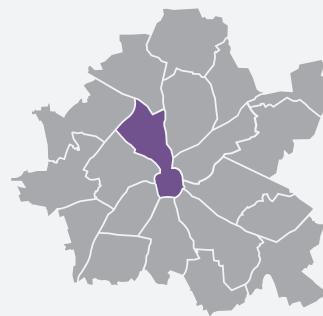
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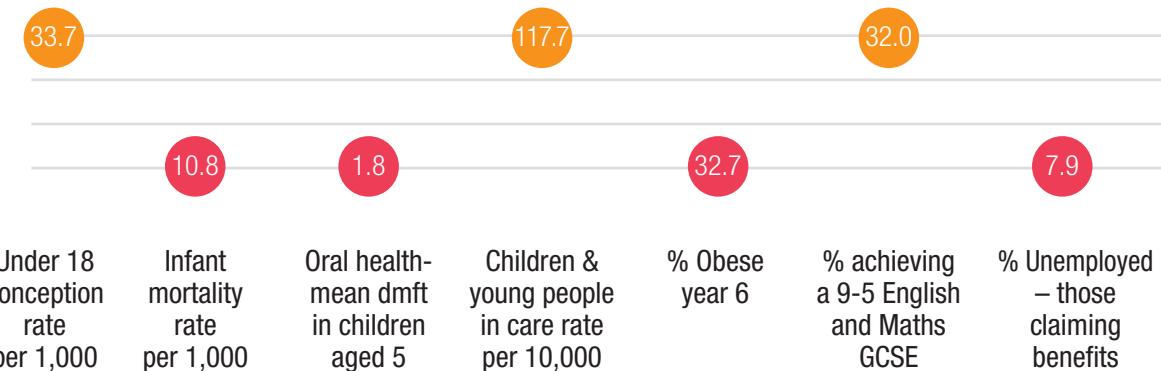
% of houses with 1 or more category 1 hazards identified	% Smoking prevalence	Rate per 100,000 diabetes prevalence	Rate per 100,000 alcohol specific admissions	% providing unpaid care provision	% with a limiting illness which limits daily activities a little or a lot	Rate per 100,000 dementia prevalence	Rate per 100,000 falls admissions 65+	Rate per 100,000 respiratory admissions 65+	% below average or very low wellbeing 65+	% Fuel poverty	Permanent placements in residential or nursing care rate per 100,000 65+
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# Your ward at a glance: St Peter's

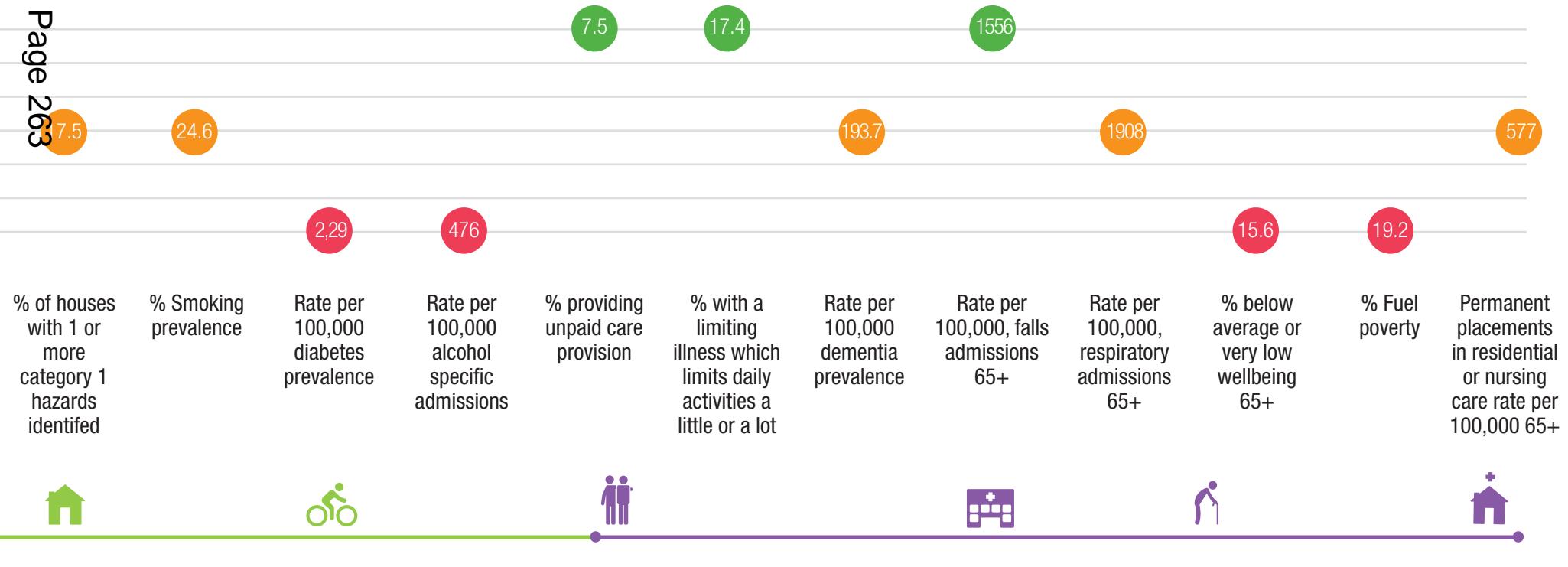


## What is life like in your ward?



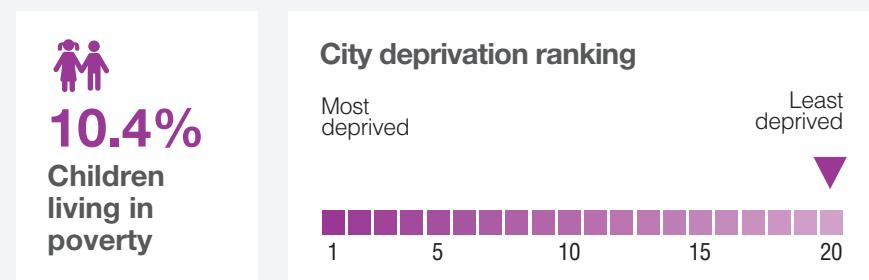
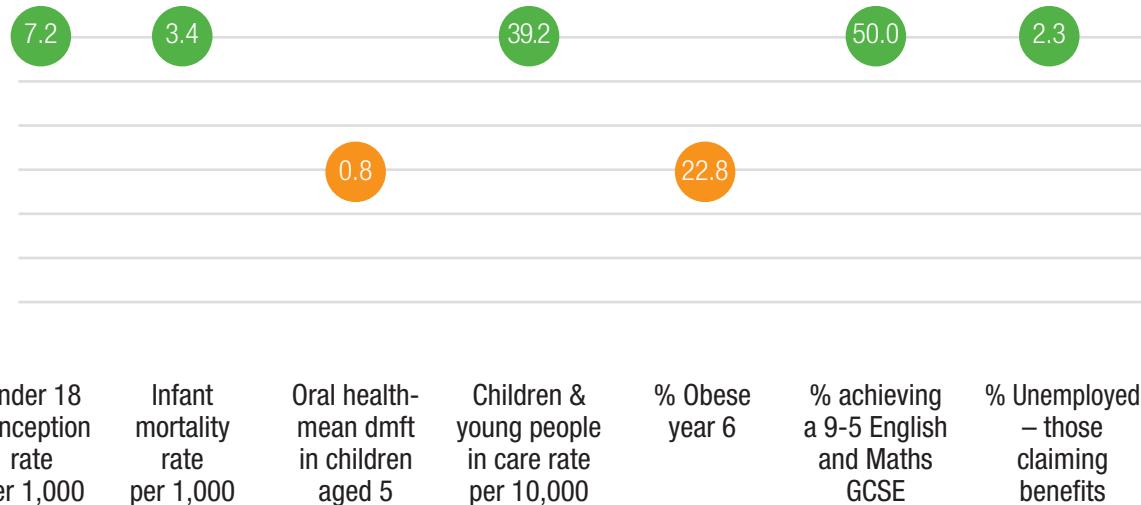
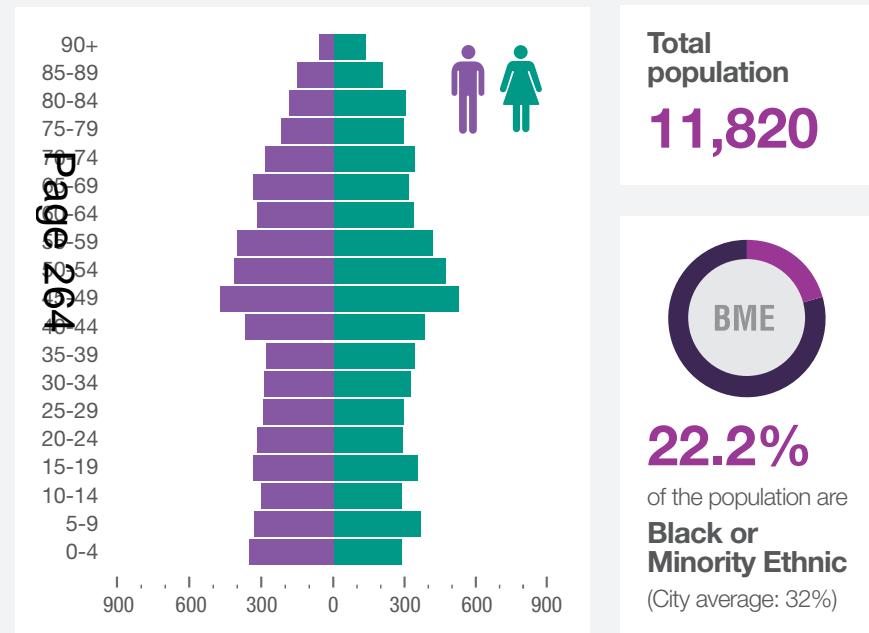
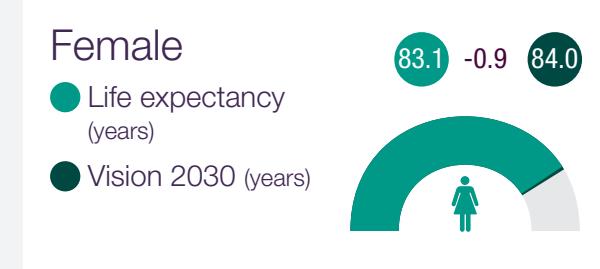
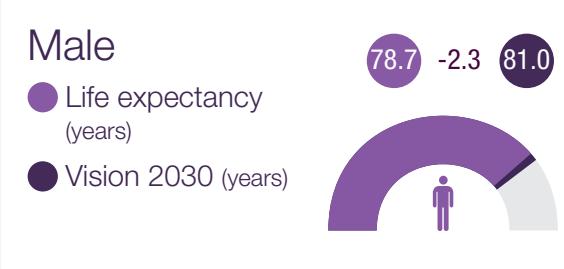


Key: Compared to city average ● Worse ● Similar ● Better



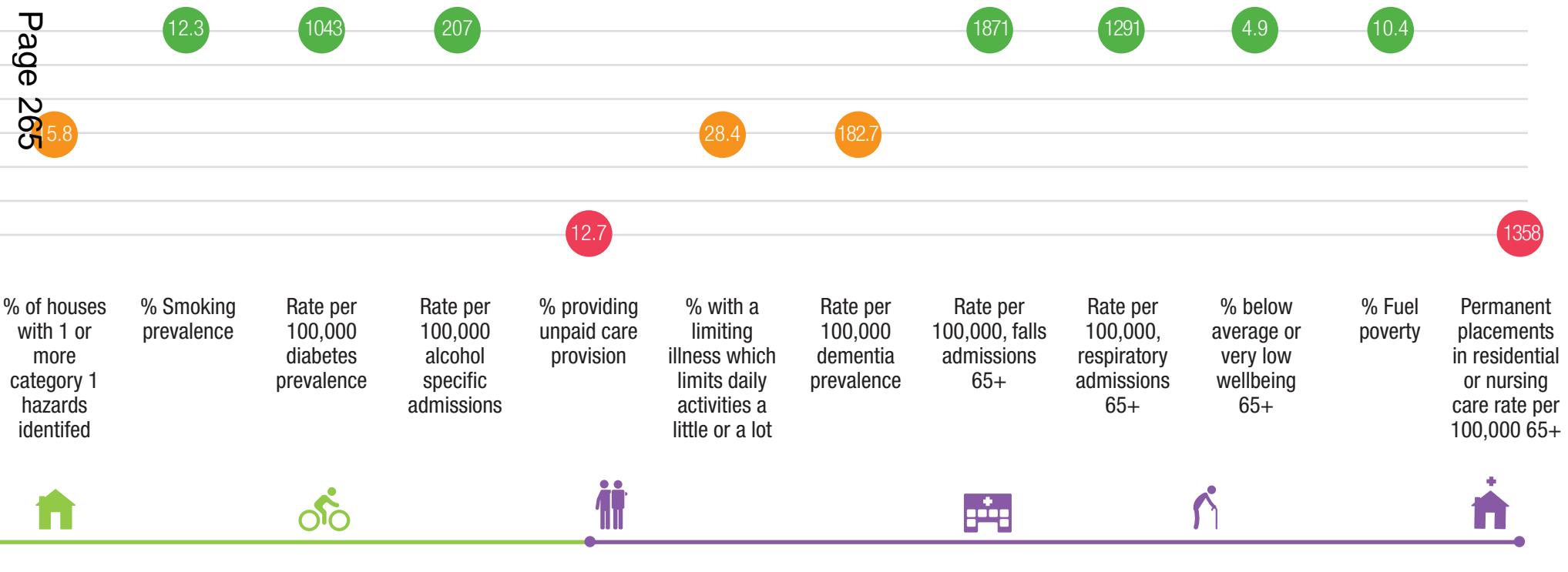
## Your ward at a glance:

# Tettenhall Regis



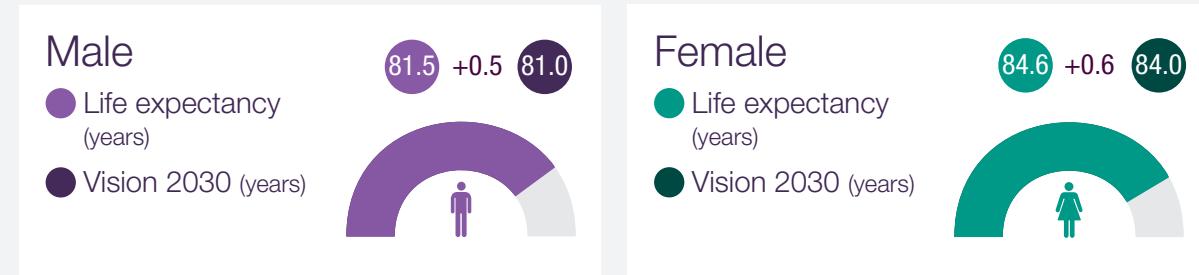
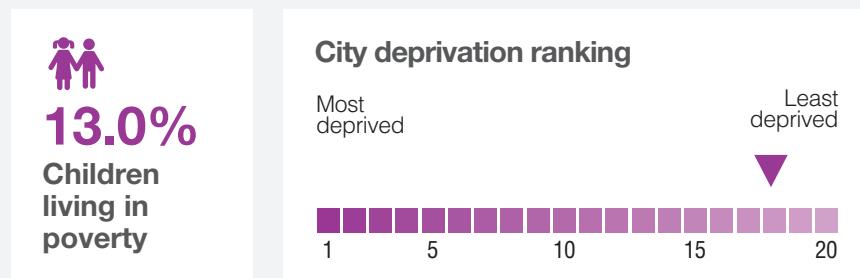
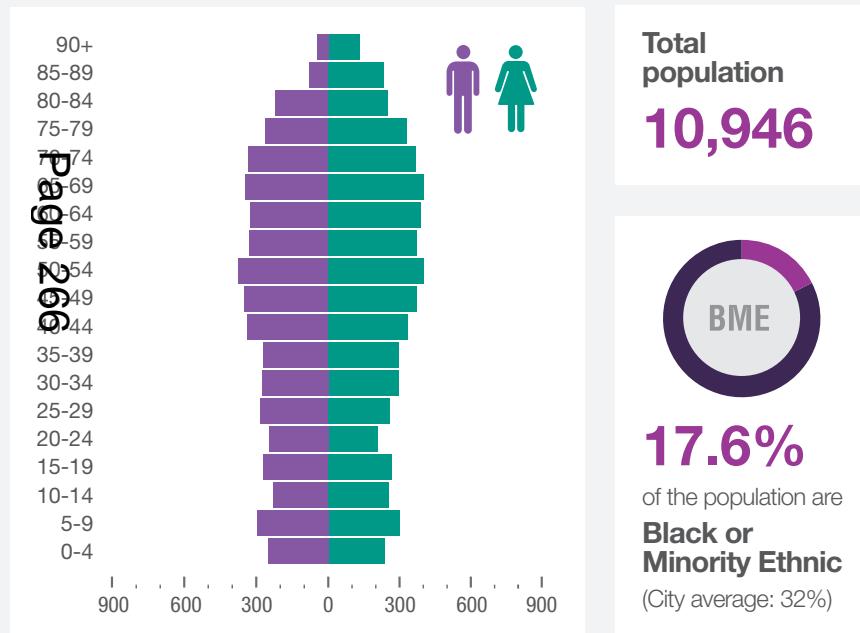


Key: Compared to city average Worse Similar Better

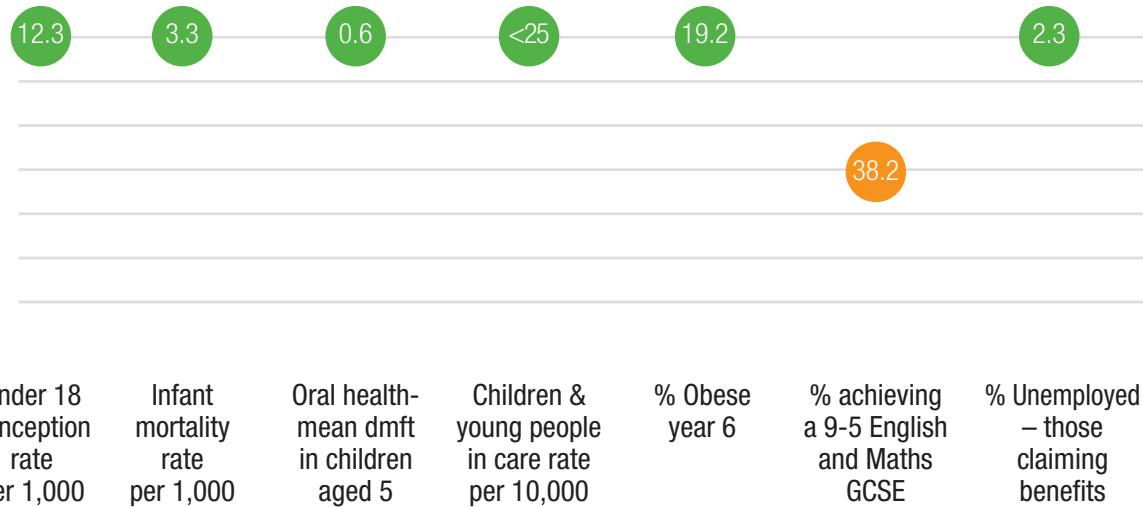


## Your ward at a glance:

# Tettenhall Wightwick

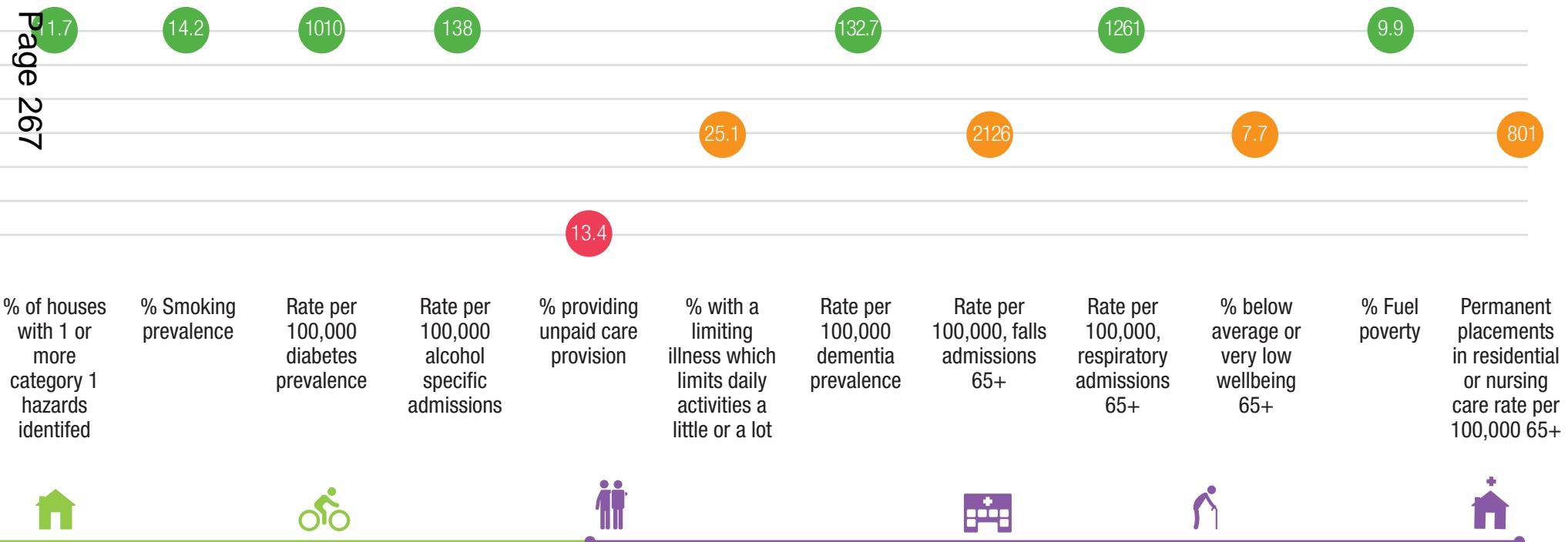


## What is life like in your ward?

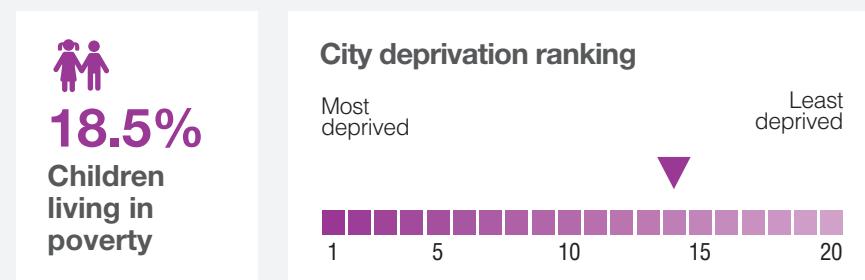
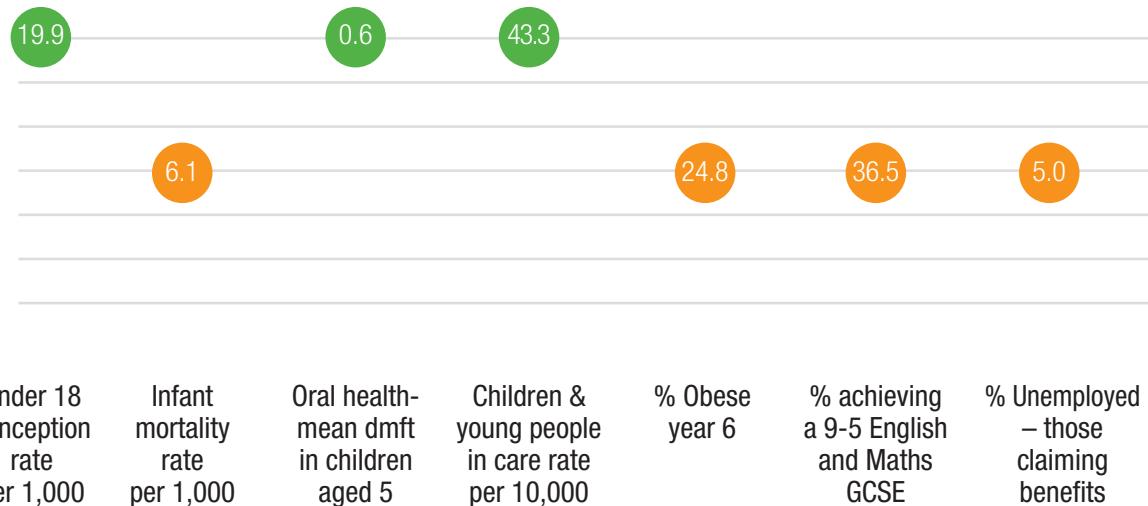




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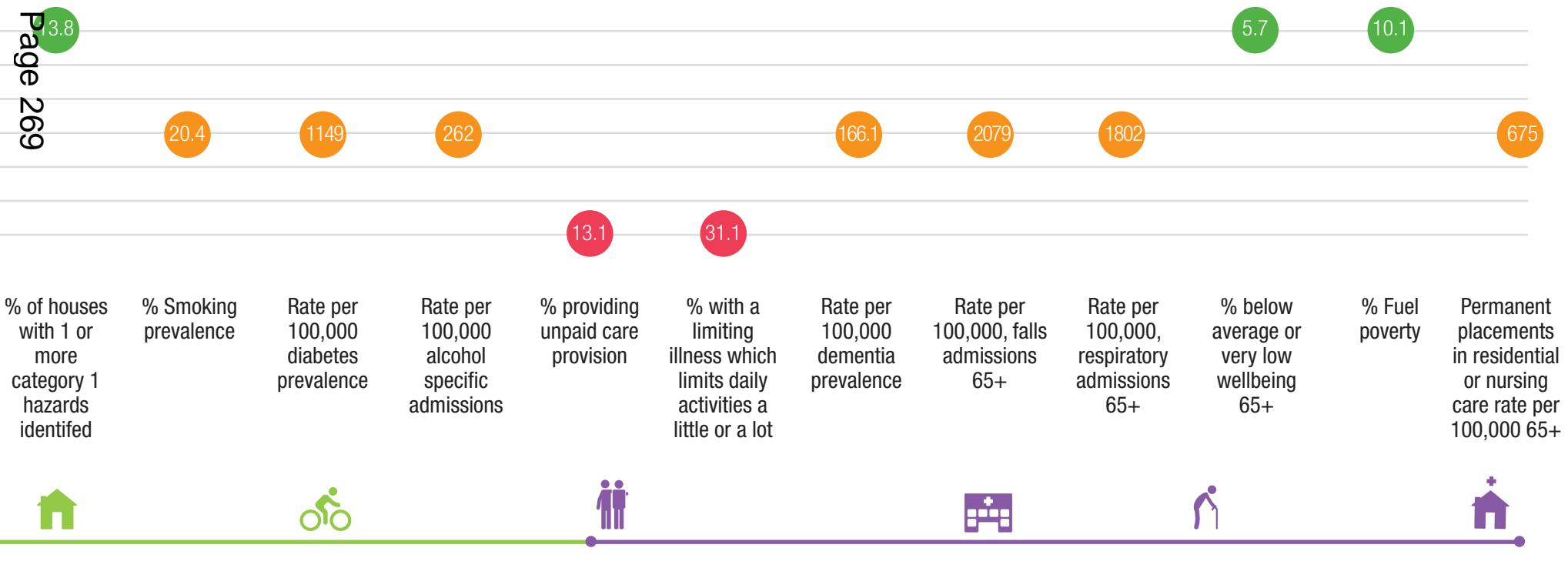


# Your ward at a glance: Wednesfield North

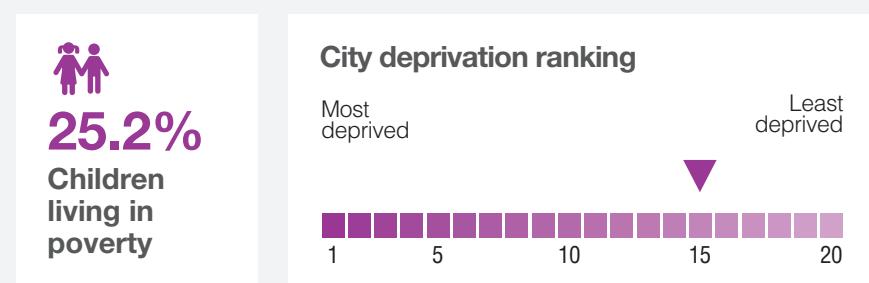
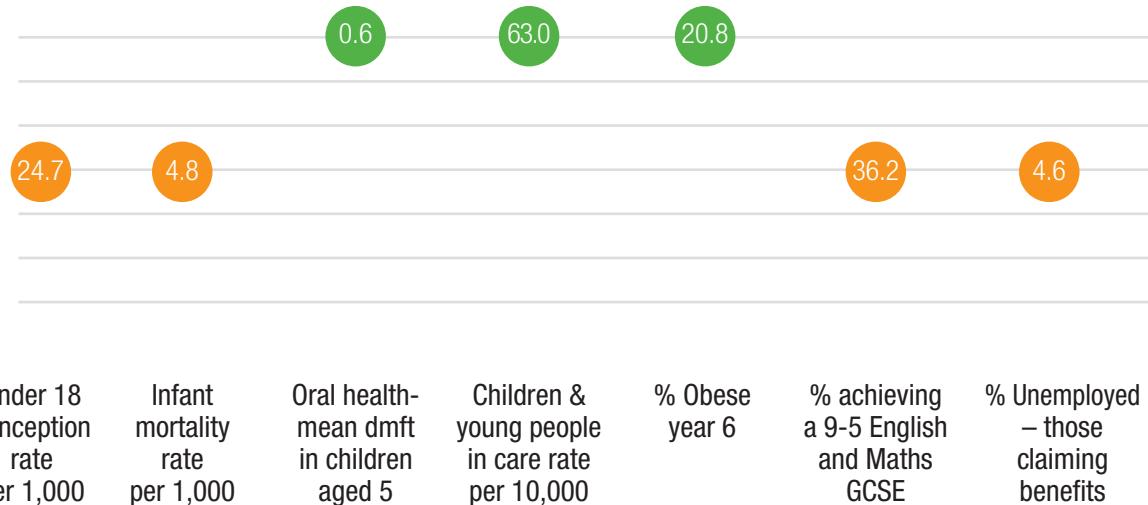
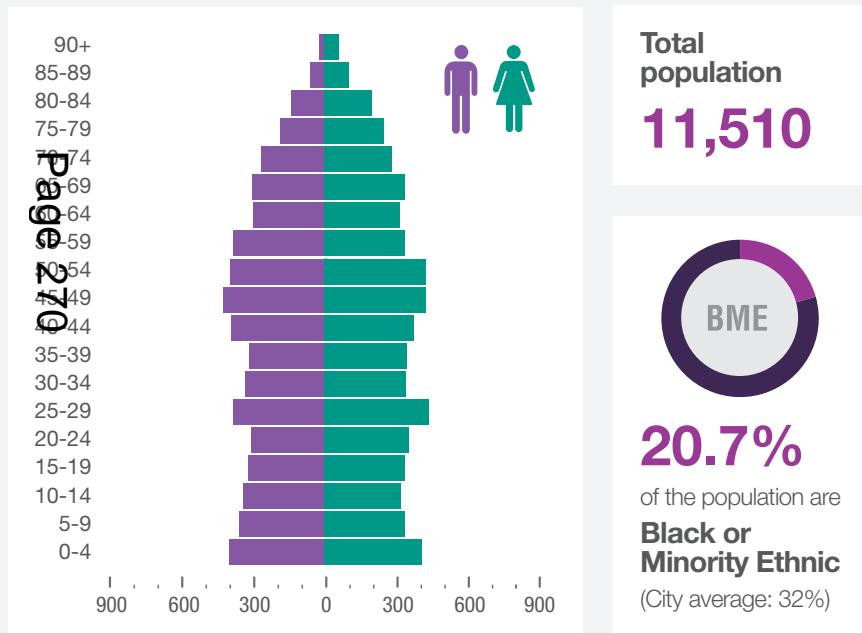




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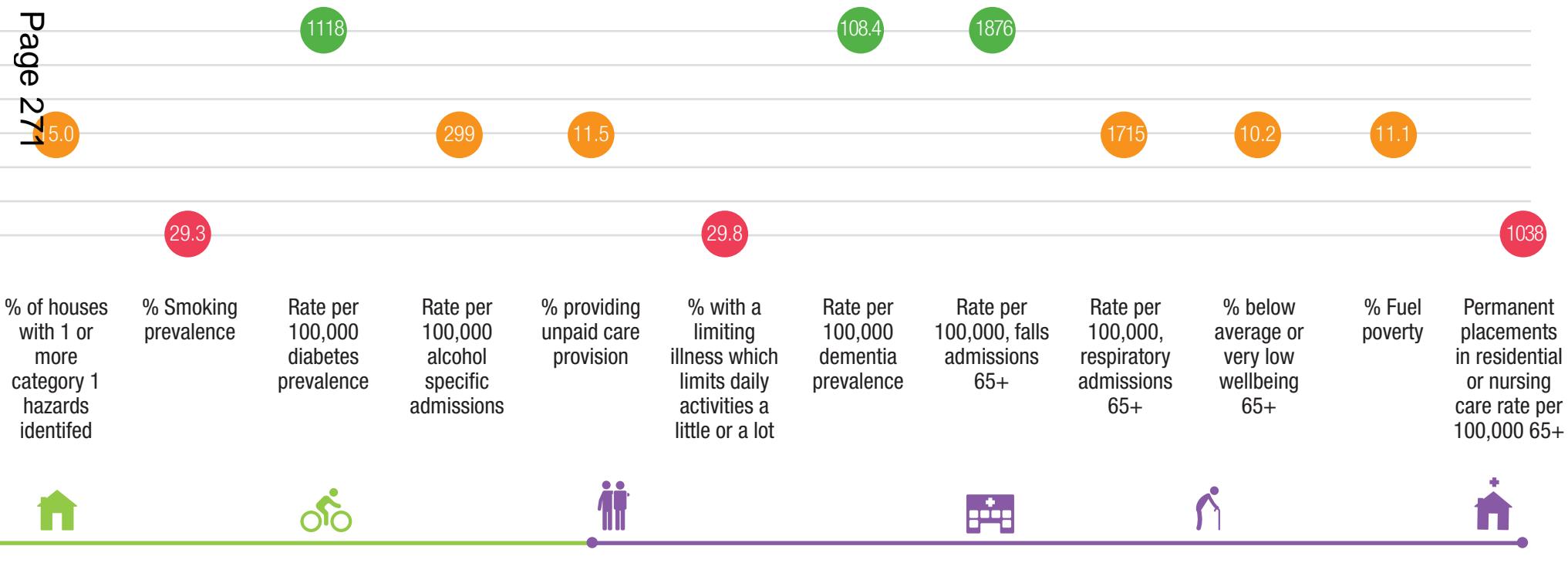


# Your ward at a glance: Wednesfield South





Key: Compared to city average ● Worse ● Similar ● Better



## Conclusion

In the last year we have made significant progress in tackling challenging public health issues by working collaboratively with partners to improve delivery of the Healthy Child Programme, NHS Health Checks and Sexual Health services.

Our innovative approach to system leadership and population health management have also helped to strengthen the strategic focus on keeping people living and aging well in our communities and preventing illness before it occurs.

Embedding health and wellbeing within the new Council Plan has strengthened our ambitions to ensure that everything we do as a Council is orientated towards an inclusive approach to promoting the holistic wellbeing of people living in the City.

Targeting resources where they are needed the most by taking a place-based approach will help us continue to work with communities and empower residents to have the capacity and capability to make a real difference to the neighbourhoods where they and their families live.

Reducing health inequalities will continue to be a driving force behind the work we do with strategic partners to create a fairer society and a City that is vibrant and health promoting.

We know there is much to do, and that many of the challenges to improving the lives of people will require innovation in the way we work with strategic partners and wider stakeholders to make a significant and tangible improvements in health outcomes over the coming year. As a public health Council, we will continue to strive to ensure that everyone in the City lives healthier, longer and more fulfilling lives.

## Further information

For more information visit:

**The vision for Public Health 2030**

[www.wolverhampton.gov.uk/public-health-vision](http://www.wolverhampton.gov.uk/public-health-vision)

**Our Council Plan 2019 – 2024**

[www.wolverhampton.gov.uk/council-plan](http://www.wolverhampton.gov.uk/council-plan)

**Joint Health & Wellbeing Strategy 2018 - 2023**

[www.wolverhampton.gov.uk/wellbeing-strategy](http://www.wolverhampton.gov.uk/wellbeing-strategy)

**Public Health Outcomes Framework**

<https://fingertips.phe.org.uk/profile/public-health-outcomes-framework>

You can get this information in large print, braille,  
audio or in another language by calling 01902 551155

**wolverhampton.gov.uk 01902 551155**

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City of Wolverhampton Council, Civic Centre, St. Peter's Square,  
Wolverhampton WV1 1SH

# Health Scrutiny Panel

7 November 2019

<b>Report title</b>	Healthwatch Wolverhampton Annual Report 2018/19
<b>Report of:</b>	Tracy Cresswell Manager Healthwatch Wolverhampton
<b>Portfolio</b>	Public Health and Wellbeing

---

## **Recommendation(s) for action or decision:**

The Health Scrutiny Panel is recommended to:

Note the attached Healthwatch Wolverhampton Annual Report 2018/2019 for information.

This report is PUBLIC  
[NOT PROTECTIVELY MARKED]

## 1.0 Introduction

- 1.1 Healthwatch Wolverhampton is the independent consumer champion for health and social care. The purpose of this report is to highlight the key achievements of Healthwatch Wolverhampton, review the projects undertaken and to understand the recommendations made for service improvement. The report also outlines key priority work areas that Healthwatch Wolverhampton will undertake during 2019/20, based upon feedback from the public and areas of concern

1.2

## 2.0 Background

- 2.1 Healthwatch England mandates that each of the 148 local Healthwatch throughout England have to produce an annual report, detailing all key Healthwatch activities and reporting on finances for the year. This is then lodged with Healthwatch England, the Care Quality Committee and NHS England to ensure that every local Healthwatch is operating effectively and transparently

## 3.0 Impact on Health and Wellbeing Strategy Board Priorities

Which of the following top five priorities identified by the Health and Wellbeing Board will this report contribute towards achieving?

Wider Determinants of Health	x <input checked="" type="checkbox"/>
Alcohol and Drugs	<input type="checkbox"/>
Dementia (early diagnosis)	<input type="checkbox"/>
Mental Health (Diagnosis and Early Intervention)	<input type="checkbox"/>
Urgent Care (Improving and Simplifying)	x <input checked="" type="checkbox"/>

## 4.0 Decision/Supporting Information (including options)

The annual report references the three main reports which Healthwatch completed during 2018/2019, namely, GP Communication, a review of Care Assessments and hospital discharge. These reports can be found on our website

[www.healthwatchwolverhampton.co.uk](http://www.healthwatchwolverhampton.co.uk) .

## 5.0 Implications

There are no known implications in relation to this report.

## 6.0 Schedule of background papers

- 6.1 The background papers relating to this report can be inspected by contacting the report writer:

This report is PUBLIC  
[NOT PROTECTIVELY MARKED]

**Tracy Cresswell**  
**Manager**

Healthwatch Wolverhampton  
Freephone: 0800 470 1944  
[www.healthwatchwolverhampton.co.uk](http://www.healthwatchwolverhampton.co.uk)

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# Annual Report 2018-19

| Engaging | Informing | Influencing |



## Contents:

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# Message from our Chair

This Annual Report details the work of Healthwatch Wolverhampton during 2018-19. It provides an overview of the work that has been undertaken and our upcoming work programme.

*It has been a busy and challenging year. Following a ‘listening tour’ and feedback from Wolverhampton residents, this year Healthwatch Wolverhampton developed a work programme which included a focus on: Hospital Discharge, Cancer Services, Domiciliary Care, GP Services, Loneliness and Isolation and Drugs and Alcohol. Healthwatch Wolverhampton core team is made up of 3 full time equivalent members of staff. Details of what we did, and outcomes are covered in this Annual Report.*

*Enter and View, a Healthwatch legal power to scrutinise the quality of health and social care services and see them in action, continues to offer a way for us to identify what is working well and where there is room for improvement. I want to thank our trained Authorised Representatives for their continued commitment to this important work.*

*In our role as influencer, Healthwatch Wolverhampton is a member of Health Scrutiny Panel and Health and Well Being Together Board. We have used intelligence and concerns raised by patients to hold service providers to account. A key area of concern in Wolverhampton has been and continues to be waiting times for cancer referrals. This has been raised with Wolverhampton Clinical Commissioning Group and Royal Wolverhampton NHS Trust (RWT) and work is underway to look at specific areas of concern.*

*Higher mortality rates in Wolverhampton have made headlines and Healthwatch has been pleased to hear Royal Wolverhampton NHS Trust Medical Examiner roles have now been implemented to undertake mortality reviews to gain insight into causes of death.*

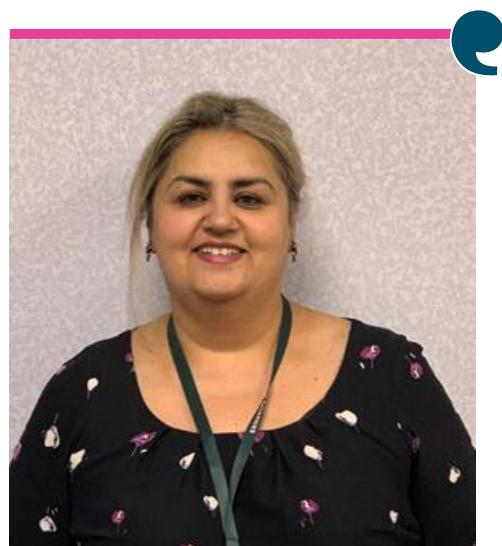
*Further to feedback from residents/patients, other areas of concern we have raised include:*

- ❖ Car parking charges and availability at New Cross Hospital
- ❖ Delays in accessing Mental Health services
- ❖ GP appointment issues

*I want to pay tribute to Healthwatch volunteers who help us in a variety of roles including community engagement which means that we actively reach out to groups (big/small, informal/organised) across the city and listen to and act on their experiences of health and social care.*

*I also want to thank Healthwatch Advisory Board Vice Chair Dana Tooby and all Board members (also volunteers) for their insight and tireless work.*

*We remain a critical friend and work with stakeholders and decision makers to bring about positive change to services in Wolverhampton.*



Sheila Gill  
Healthwatch Wolverhampton Chair

# About us

**Healthwatch is here to make health and social care better.**

We are the independent champion for people using local health and social care services. We listen to what people like about services and what could be improved. We share their views with those with the power to make change happen. People can also speak to us to find information about health and social care services available locally.

**Our sole purpose is to help make care better for people.**

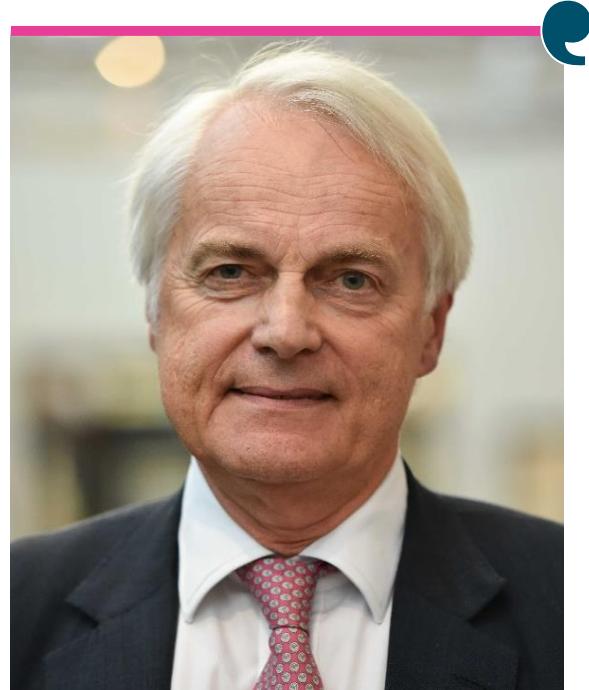
*As Chair of Healthwatch England, it's my role to make sure your Healthwatch gets effective support and that national decisions are informed by what people are saying all over England.*

*If you were one of the 400,000 people who shared their experiences with us last year, I want to say a personal thank you. Without your views, Healthwatch wouldn't be able to make a difference to health and social care services, both in your area and at a national level. One example of this is how we shared 85,000 views with the NHS, to highlight what matters most, and help shape its plans for the next decade.*

*If you're part of an organisation that's worked with, supported or responded to Healthwatch Wolverhampton, thank you too. You've helped to make an even bigger difference.*

*None of this could have been possible without our dedicated staff and volunteers, who work in the community every day to understand what is working and what could be better when it comes to people's health and care.*

*If you've shared your views with us then please keep doing what you're doing. If you haven't, then this is your chance to step forward and help us make care better for your community. We all have a stake in our NHS and social care services: we can all really make a difference in this way.*

The signature of Sir Robert Francis QC, written in black ink. It consists of a stylized, flowing script that reads "Robert Francis".

**Sir Robert Francis QC**  
Healthwatch England Chair

## Our local vision is simple

Health and social care that works for you. People need health and social care support that works - helping them to stay well, manage any conditions they face and to get the best possible care from services.



## Our local purpose

To find out what matters to you and to help make sure your views shape the support you, your families and your communities need.



People's views come first - especially those that find it hardest to be heard. We champion what matters to you and work with others to find solutions. We are independent and committed to making the biggest difference to you.



## Wolverhampton Health Advocacy Complaints Service

Healthwatch encourages partnership working and continues to enjoy being co-located with the Wolverhampton Health Advocacy Complaint Service (WHACS), with an advocate working from the Healthwatch offices. The advocacy service is a separate service which receives independent funding to that received by Healthwatch but we co-locate as we see the real synergies between the two contracts, with Healthwatch gaining valuable insight from the themes and trends coming through from the advocacy cases.

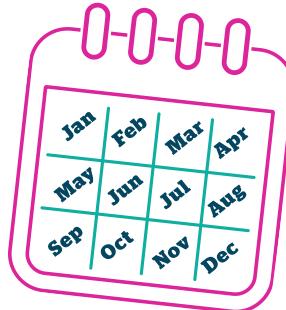
## Wolverhampton people are at the heart of everything we do

We play an important role in bringing communities and services together across Wolverhampton. Everything we do is shaped by what people tell us. Our staff and volunteers identify what matters most to people by:

- ❖ Visiting services to see how they work
- ❖ Running surveys and focus groups
- ❖ Going out in the community and working with other organisations

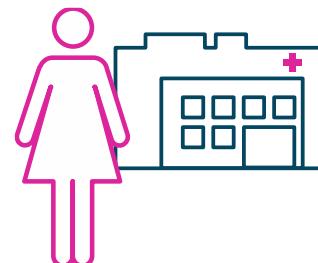
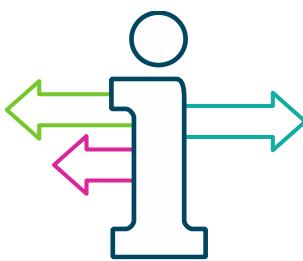
Our main job is to raise people's concerns with health and care decision makers so that they can improve support across the country. The evidence we gather also helps us recommend how policy and practice can change for the better.

# Highlights from our year 2018-19



**3344** people have engaged with us in the community

We have published **5** reports, ranging from GP Communications to Care Assessments

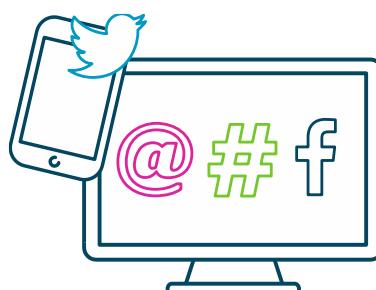


**4351** calls were received and **122** people were signposted to additional services or our Advocate

We attended **193** events and activities in the community, see [page 7](#) for a list of our activities and events attended



**112** new members were signed up, adding to our ever growing members list to receive news and information



**70,298** social media accounts have seen our posts

Throughout the year we have undertaken community outreach activities whilst attending and engaging with diverse communities in Wolverhampton, including:

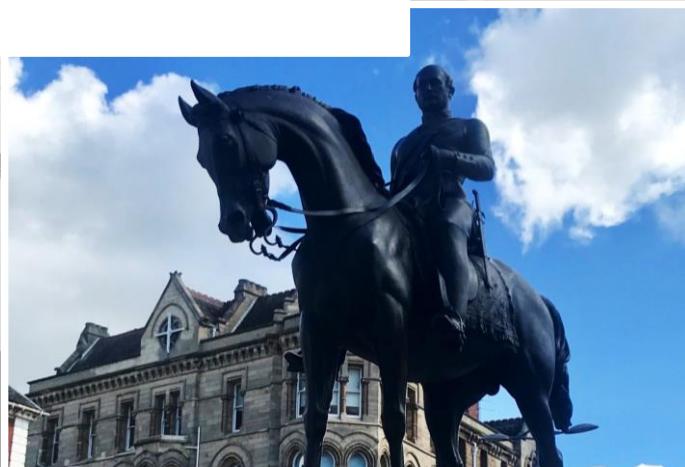
- ❖ All Saints Church All Saints Action Network (ASAN) Open Day
- ❖ Antibiotics Week at Wolverhampton College Campus
- ❖ Beacon Centre - Local eye health conference
- ❖ Black Country Neurological Alliance Event
- ❖ Building Bridges Refugee Migrant Centre
- ❖ Café Neuro
- ❖ Carers Celebration Day by African Caribbean Community Initiative
- ❖ Carers Day Event
- ❖ Choose to Change St Peters Church Social Hub Group
- ❖ Christian Life City Church Community Fun Day
- ❖ Coffee morning Support Group
- ❖ Deaf Event Low Hill Community Centre
- ❖ Dementia Action Alliance relaunch Excel Church Bilston
- ❖ Dementia Action Week Event Bob Jones Community Event
- ❖ Dementia Cafe across the city
- ❖ Department for Work and Pensions Job Fair at Molineux House Temple St
- ❖ Diabetes Groups across the city
- ❖ Drop in at Avion Group - St Andrews Church
- ❖ Drop in at Bob Jones Community Hub
- ❖ Drop in at Central Baths
- ❖ Drop in at Central Library
- ❖ Drop in at Deansley Centre New Cross
- ❖ Drop in at East Park Care Home
- ❖ Drop in at Elms Care Home
- ❖ Drop in at Emergency Department New Cross
- ❖ Drop in at Greggs Café New Cross
- ❖ Drop in at Let us Play Group
- ❖ Drop in at Low Hill Community Centre
- ❖ Drop in at Moreland Trust
- ❖ Drop in at P3 café
- ❖ Drop in at Tettenhall Special School coffee morning
- ❖ Drop in at The Lighthouse
- ❖ Drop in at the Tettenhall Institute
- ❖ Drop in at the Urgent Care Centre New Cross
- ❖ Drop in at Wolverhampton Art Gallery
- ❖ Drop in at Wolverhampton Elder Asian Disabled Group Darlington St Methodist Church
- ❖ Drop in at Wolverhampton University Student Union
- ❖ Equality & Diversity Launch
- ❖ Faith Forum Wolverhampton Voluntary Sector Council
- ❖ Freshers Fayre Wolverhampton Campus
- ❖ Good Shepherd Church Support Group
- ❖ GP drop in All Saints and Rosevillas Medical Practice
- ❖ GP drop in at Ashfield Road Surgery
- ❖ GP drop in at Dr Fowler's Practice
- ❖ GP drop in at Lea Road Medical Practice
- ❖ GP drop in at MGS Medical Practices
- ❖ GP drop in at Newbridge Surgery
- ❖ GP drop in at Pennfields Medical Centre
- ❖ GP drop in at Probert Road Surgery
- ❖ GP drop in at Tettenhall Road Medical Practice
- ❖ GP drop in at Thornley Street Surgery
- ❖ GP drop in at Tudor Medical Practice
- ❖ GP drop in Bilton Urban Village Medical Centre
- ❖ GP drop in Castlecroft Medical Practice
- ❖ GP drop in Coalway Road Surgery
- ❖ GP drop in Pendeford Health Centre
- ❖ GP drop in Penn Manor Medical Practice
- ❖ Lesbian Gay Bisexual Trans Alliance
- ❖ Pendeford Fun Run Day at Pendeford Shopping Centre
- ❖ Phoenix Group Mental Health Support Group, Wednesfield
- ❖ Roz Cole Carers Group, Merridale
- ❖ Talking Points, Old School, Dudley Rd
- ❖ Tea & Chat, Central Library
- ❖ Tenants Association Meeting at Molineux
- ❖ The Friends Coping Group, St Patricks Church Wednesfield
- ❖ The Low Hill Group at the Church of The Good Shepard
- ❖ Time to Talk at West Park
- ❖ Wednesfield Dementia Cafe
- ❖ Wolverhampton City Antimicrobial Stewardship Programme at New Cross
- ❖ Wolverhampton College Open Day
- ❖ Women & Families Resource Centre Family Event, West Park

# Making a difference



“The range and quality of questions today was spectacular and frankly we could have talked another hour and still not done them justice. You should be very proud of being able to rustle up such rich gatherings”

*Jeremy Vanes  
Chair of Royal Wolverhampton NHS Trust (2018)  
Feedback at our Annual General Meeting in July 2018*



## Making a difference locally

This year we have been able to make a difference locally by working together with our partners, volunteers and the community on a number of key priorities.

### 2018-19 Priorities

#### 1. GP Communication

During the Listening Tour, access to GP's remained a priority for members of the public. Work had previously been carried out by Healthwatch to understand issues around access to appointments. We were aware that changes were taking place in General Practice and we wanted to understand how these were being communicated to patients.

**Over 500** patients completed surveys during August and first week of September 2018, through various drop-ins at GP practices, Wolverhampton College Freshers Fayre and Carvers Marathon to name just a few of the areas we went. In addition, our survey was shared through social media and on our website.



Below are some of the findings:

- ❖ **27%** of patients said they received regular information from their practice, however **73%** did not and the information received related to appointments, prescription reminders etc.
- ❖ **24%** of patients were aware of their Patient Participation Group (PPG) and **76%** were not aware of the PPG, but **51%** would be interested in joining their PPG
- ❖ Issues with interpreting services not being available for PPG meetings

#### 2. Cancer

Wolverhampton was around the national average for the early diagnosis of cancer and had higher than average rates of premature deaths from cancer. In Wolverhampton there were concerns around the 2 week wait for referral and subsequent delays in treatment.

The Wolverhampton Clinical Commissioning Group (WCCG) were working with Royal Wolverhampton NHS Trust (RWT) to bring these rates down.

West Midlands Cancer Network were also aware of these issues, so it was agreed that Healthwatch would defer this project to 2019/2020.

### 3. Isolation and Loneliness

Social isolation and loneliness is a major issue in modern Britain and feedback from the public suggests this is also the case in Wolverhampton.

Social isolation and loneliness can affect anyone at any point in their life, but some groups are more susceptible such as someone that is housebound, older people, recently bereaved, young parents, people with long term health conditions and mental health issues. We decided to concentrate on the experiences of housebound and young new moms.

We carried out **33** surveys with patients / residents who were housebound; we worked with domiciliary care providers and community nurses to get surveys completed. We also carried out focus groups to understand the experience of young new moms around isolation and loneliness following their discharge from hospital.

We are hoping to move to phase two of the project and have extended it to 2019/20 before we collate our findings.

---

### 4. Care Assessments

In 2016 Healthwatch took part in national research with Healthwatch England looking into delays in care assessments for those who were resident in residential care homes. The research targeted care home managers to understand their experiences of delays in assessments and the impact this was having.

We replicated the original survey in July / August 2018 to identify any changes made in the delivery of care assessments, care packages and care reviews.

**54** homes received the survey via e-mail; only **14** care homes responded to the survey.

The overall findings were in line with the results in 2016 with some nominal improvement in the timeliness of care reviews being undertaken.

Recommendations suggested;

- ❖ Consideration should be given to providing interim financial support to care home residents who are awaiting assessment and lack resources to meet costs themselves.
- ❖ Process is put in place to expedite reviews where a request for an urgent review is made by a service provider due to change in health or needs of a current service user.
- ❖ Process for prioritisation of care assessments for service users on step down placement.



## 5. Drug and Alcohol Services

The public identified that they wanted this to be a priority for Healthwatch, however due to the services being recommissioned it was agreed that a mapping exercise would take place to understand the services that were currently available in the community to support individuals with drug and alcohol issues.

The following services were identified:

- ❖ Recovery Near You - Wolverhampton Substance Misuse Service
- ❖ The following services are delivered by Aquarius, Nacro and Birmingham and Solihull Mental Health Trust;
  - ❖ Substance misuse services for adults, young people and families
  - ❖ Drug and Alcohol Hospital Liaison Team
  - ❖ Criminal Justice Interventions
  - ❖ Specialist Alcohol Team
- ❖ Service User Involvement Team (SUIT)
- ❖ Smart recovery - self management and recovery training
- ❖ Alcoholics Anonymous (AA)

## 6. Discharge

Discharge from hospital was a concern for the public. As part of Discharge 2 Assess (D2A) Steering Group, Healthwatch realised that the patient voice and experience was not being listened to.

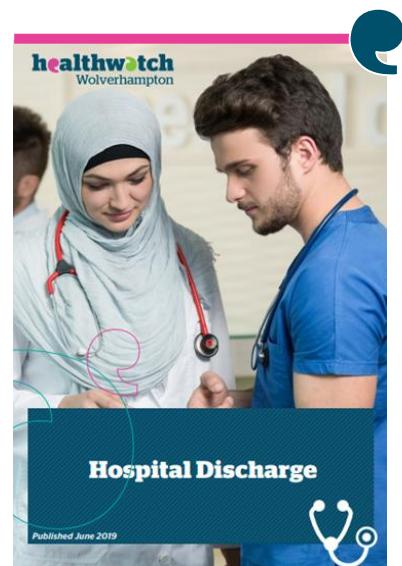
101 patients were interviewed by volunteers and staff whilst in hospital to gain an understanding of their involvement with their discharge. There were two parts of this report and patients were contacted at an agreed date following discharge. The patients interviewed were inpatients at Royal Wolverhampton NHS Trust, West Park and Cannock Hospital.

The patients that we engaged with during their stay in hospital had mixed responses to how or if they were engaged around their discharge plans; a number of the patients we followed up had sadly passed away and their relatives answered the questions.

There were a number of recommendations including;

- ❖ Family members should be involved in the discharge planning process
- ❖ One single point of contact needed for patients to liaise with for their discharge
- ❖ Patient concerns to be taken into account when planning discharge.

Healthwatch has highlighted the importance of the patient voice during the planning of discharge from hospital.



## Other areas of work

### Urgent Care Centre

We had previously carried out surveys at the centre and made a number of recommendations, we were pleased to see that there had been improvements from our recommendations.

We carried out surveys from 24<sup>th</sup> September to 30<sup>th</sup> September 2018 and we covered various times of the day, including out of hours and weekends and a maximum of 2 hours were spent at each visit made by staff and volunteers.

Overall, the Urgent Care Centre was quiet during the times that we were there and the experience was mainly positive from the patients who we spoke to. However, there were still some areas for improvement from the Urgent Care Centre to the patients:

- ❖ More information is required around the Urgent Care Centre and what ailments they can treat.
- ❖ More information needs to be available for patients who wish to make a complaint.

There was still confusion around the walk-in patients and patients who had made an appointment via NHS 111.



Jane, one of volunteers, helping us to complete surveys at the Urgent Care Centre

### End of Life

We were commissioned to carry out some engagement work with patients experience and understanding of Advance Care Plans. Focus groups were carried out at Dementia Cafes, the Deaf community coffee morning, and the ACCI (African Caribbean Community Initiative) carers group to gain their understanding on advance care plans.

There was a range of understanding of what Advance Care Plans are. There were mixed feelings about starting a conversation around End of Life for some individuals, others were open about having a discussion, some did not want to think about it.

A report was produced and shared with the WCCG and Integrated Care Alliance as End of Life is one of the areas that they are working on. The Medical Director of Royal Wolverhampton NHS Trust said it was a well written and informative report.

In addition, surveys were also shared with people who had lost a loved one within 12 months. This report has been shared with the WCCG.



Tracy holding a forum on End of Life

## Deaf community

As part of our ongoing work with Deaf and hearing-impaired individuals, we have worked with Zebra Access, commissioners and providers to understand the issues this community have around various health areas.

In August 2017, Healthwatch held an event to gain an understanding of experiences in health and social services. This resulted in the development of a report which had **23 recommendations**. The Deaf community felt that they had been listened to but that no action was taken to follow up their feedback.

We brought together Wolverhampton City Council commissioners, Wolverhampton Clinical Commissioning Group, Urgent Care providers and Royal Wolverhampton NHS Trust to pull together responses to the recommendations. We held an event in September 2018 where the Deaf community learnt about what actions were being carried out following the publication of the report and its recommendations. They were also given an opportunity to ask additional questions or clarify anything that they needed more information about.

**This event was well received by the Deaf community as they felt that their voices had been not just listened to but things were being looked at seriously, with changes being made to improve their experience.**

There were several outcomes that came from the launch including:

- ❖ Healthwatch and Wolverhampton City Council to produce a card that would support both the Deaf and hearing impaired; this will reduce the anxiety about having to book an appointment and asking for an interpreter or needing a hearing loop.
- ❖ Healthwatch to facilitate Health Forums for the Deaf community by working with Zebra and speakers for the health areas identified by the community. The venue, dates, times were agreed by the community. They wanted what hearing people had, around understanding the signs they need to look out for and have awareness around health topics.  
**“Healthwatch Wolverhampton have worked closely with Zebra Access to improve the well being and health care the Deaf community receive, this has had it successes and we hope we can continue to support the cause.”**

*Sean Noone  
Community Development Officer, Zebra Access*



September's meeting following the publication of the Deaf report

Health Forums have taken place so far, with more being planned.

- ❖ **Dementia Forum** was delivered by the Alzheimer's Society who carried out Dementia Friends awareness sessions, and 7 members became Dementia Friends.
- ❖ **Mental Health Forum** was delivered by the lead Mental Health commissioner of WCCG on what is commissioned and who provides the services. The group would have liked to have had more information around the various mental health conditions and the commissioner was happy to come back to the group and let them know.
- ❖ **Cancer:** the group wanted to understand the different forms of cancer and the signs and symptoms, This forum will be delivered by RWT and WCCG.
- ❖ **Diabetes:** again to understand the different forms of diabetes and the signs and symptoms, this forum will be delivered by Diabetes UK



Deaf Forum attendees with their Dementia Friends certificate

In addition to ongoing work with the group, we have carried out focus groups around End of Life.

Healthwatch have attended Zebra Access's coffee morning to carry out a talk about Healthwatch and to understand the issues with the interpreters that are currently being commissioned.

The report and recommendations were presented at the Health and Well Being Board in January 2019. It was well received and **the recommendations were accepted.**

**Healthwatch have been informed that the leader of the City of Wolverhampton Council has commenced discussions between the Council and NHS to look at commissioning interpreters jointly, rather than the WCCG, RWT and Council all using different interpreting organisations. This would help resolve some of the issues identified by the Deaf community, who felt that there was no consistency to quality of provision.**

We have worked with Zebra Access and Independent Living Sensory Service to develop a communication card to help reduce some of the anxiety and difficulties faced by people who are Deaf or hearing impaired.

So far 22 cards have been handed out and we will continue to work with the Deaf community to see if this has had a positive impact on allowing people to access services.



Name _____
I communicate using: (Please tick all that apply)
<input type="checkbox"/> British Sign Language (BSL)
<input type="checkbox"/> Book me a BSL interpreter
<input type="checkbox"/> Book me a double appointment
<input type="checkbox"/> I lip-read / hearing aid user, please look at me

## Strategic relationships

Healthwatch Wolverhampton acts as a critical friend to local strategic partners and plays an active role in representing your views. We have attended many strategic and operational meetings as listed below:

- ❖ Action for Hearing Loss
- ❖ Better Care Fund
- ❖ Black Country Healthwatch
- ❖ Black Country Partnership Foundation Trust (BCPFT) Engagement Meeting
- ❖ Café Neuro Co-ordinators Meeting
- ❖ Cancer Strategy
- ❖ Cannock Hospital Quality Visit
- ❖ Care Home Manager, East Park
- ❖ Care Quality Commission (CQC) Information Sharing
- ❖ Children and Adolescent Mental Health Commissioner Meetings
- ❖ Clinical Commissioning Group Self Care Assessment
- ❖ Dementia Action Alliance
- ❖ Dementia Strategy Group
- ❖ Deterioration Patients Task Group
- ❖ Discharge to Assess (D2A)
  - Steering Group
  - Communications and Engagement Group
  - Internal Audit for Discharge to Assess
- ❖ Domiciliary Care Providers Group
- ❖ Early Help Strategy
- ❖ Emergency Department Lead and Royal Wolverhampton NHS Trust (RWT)
- ❖ End of year CCG Assurance Meeting with NHS England
- ❖ Executive Commissioning Group
- ❖ Head of Patient Experience Team
- ❖ Health and Scrutiny Panels
- ❖ Health and Wellbeing Board
- ❖ Health and Wellbeing Event for Cancer Patients
- ❖ Health Workstream Meetings
- ❖ Healthwatch England Conference
- ❖ Healthwatch Network
- ❖ Improvement and Assessment Framework (IAF) Patient and Public Participation Workshop

- ❖ Integrated Care Association Meetings Including:
  - Governance
  - Clinical
  - End of Life Subgroup
  - Frailty Subgroup
  - Children and Young People Subgroup
  - Mental Health Subgroup
- ❖ Joint Engagement Assurance Group (JEAG)
- ❖ Maternity Voices Partnership
- ❖ Meeting with the Deputy Chief Nurse from Wolverhampton Clinical Commissioning Group (CCG)
- ❖ Mental Health Stakeholders Forums
- ❖ Mortality Reduction
- ❖ NHS Long Term Plan
- ❖ NHSE Cancer Alliance Meeting
- ❖ Patient Participation Group Chairs and Citizens Forum
- ❖ Peer Review City Council
- ❖ Primary Care Committee
- ❖ Quality and Performance Committee
- ❖ Quarterly meeting with Care Quality Commission
- ❖ Royal Wolverhampton NHS Trust Annual General Meeting
- ❖ Safeguarding Board:
  - Mental Health Audit
  - Parents with Disabilities Audit
  - Internal Audit for Discharge to Assess
- ❖ Safeguarding meetings
- ❖ Safer Provision and Caring Excellence (SPACE) programme Care Home Improvement
- ❖ Special Health Scrutiny Panel (Mortality Rates)
- ❖ Stakeholder event at Beacon Centre
- ❖ Stakeholder event with BCPFT and Dudley and Walsall Mental Health
- ❖ Sustainable Transformation Partnership and Senior Responsible Officer
- ❖ System Development Board
- ❖ University of Wolverhampton Nursing Curriculum Launch
- ❖ Vocare Improvement Board
- ❖ WCCG Annual General Meeting
- ❖ WCCG Commissioners
- ❖ WCCG Governing Body
- ❖ West Midlands Care Association
- ❖ Wolverhampton Information Network Stakeholders
- ❖ Wolverhampton Lesbian, Gay, Bisexual and Trans Alliance

## Spotlight on Mental Health

We held a Spotlight event in November 2018 themed around Mental Health Services. This included guest speakers from City of Wolverhampton Council, Wolverhampton Clinical Commissioning Group, Public Health and Black Country Partnership Foundation Trust.

The meeting was well attended by members of the public who were able to hear how the commissioners and providers work together around Mental Health Services in Wolverhampton.

There were opportunities throughout the presentations for the public to ask challenging questions to the speakers.

It was clear from the questions and discussions during the meeting, that the processes and explanations of how services work was not the same as the understanding and the lived experiences of some of the service users who were in the room. In particular, accessing services and the re-admission process was not straightforward.

It was felt that it was not as simple as the explanations given and that timeframes were not met; some service users waiting up to 6 months to access the services which is contrary to the 2 weeks for the Psychology service and 7 weeks for young people under the Transformation team.

The service users who attended the meeting, felt that you needed to be in crisis to get help, one said:

**“It seems the only way to get access to treatment is to self-harm or be a risk.”**

Another area that was challenged, was GP's understanding of mental health, and the process for accessing services.



A number of people in the room asked about the rising numbers of young people who seem to have mental ill health, such as; anxiety and depression.

**“I work at the local college, and we are seeing more and more young people coming from school to college with pre-existing mental health problems”**

One service user challenged the knowledge and behaviour of security staff in the Emergency Department towards people who are displaying mental health conditions. This experience was shared by others. Due to the times that GP's and mental health services can be accessed; people are often forced to go to the Emergency Department to seek help. When people present at the Emergency Department with challenging behaviour because of their mental health condition, they are often treated by security in the same way that someone who is causing a problem. This often makes the situation worse and has a negative impact on the mental health of the person.

Healthwatch also asked how other professionals such as Healthwatch staff, Housing Officers and teachers can make referrals or better support the people that they have come in to contact with.

Healthwatch has tried to raise Safeguarding issues in the past following concerning disclosures made to us by people with mental health concerns. However the response has always been **“Mental Health is not a safeguarding issue”**, despite other local authorities considering it to be a safeguarding issue.

## Dementia Friends

We have been active members of the Dementia Action Alliance which aims to make Wolverhampton a Dementia Friendly city.

This year all our staff have taken part in Dementia Friends sessions, with two members of staff becoming Dementia Champions, which allows us to share information to other members of the community. We aim to have all our board members and volunteers become Dementia Friends and this will be incorporated in to our induction process.



During our Enter and View visits, we include questions around dementia and we regularly include recommendations to service providers to encourage our local health and social care services to become dementia friends. **This has resulted in request from some services for Dementia Friends sessions**

## Antibiotics Week

In November 2018, the staff team and volunteers completed their “Antibiotics Guardian” training and then engaged the community to talk about antibiotic resistance and help bust some myths.

The staff team, volunteers and our student placements went out in the community everyday talking to people and finding out their experience of antibiotics use and what they expected from services.

A social media campaign also took place, with a poll being run each day. We learned that people didn't fully understand the use of antibiotics, how resistance is built up and that people didn't understand the official campaign information.



Your Antibiotic Guardians

During the week we engaged with **198** people in the community and our social media campaign reached **8,100** people and received **411 interactions** including **93 votes** in our online True or False polls. At least one member of the public signed up to become an Antibiotic Guardian because of our social media activity.

**“Healthwatch did an outstanding job of supporting the collaborative effort to raise awareness of antibiotic resistance in Wolverhampton. They interacted with members of community face-to-face stalls and through a highly successful social media campaign in which they promoted Public Health England’s Keep Antibiotics Working Campaign and dispelled myths about antibiotics and antibiotic resistance.”**

**The Wolverhampton Joint Antimicrobial Stewardship Programme team were delighted to see staff and volunteers taking these important messages beyond the healthcare environment into community settings.”**

*Dr Mike Cooper  
Microbiologist and AMR Lead at Royal Wolverhampton NHS Trust*

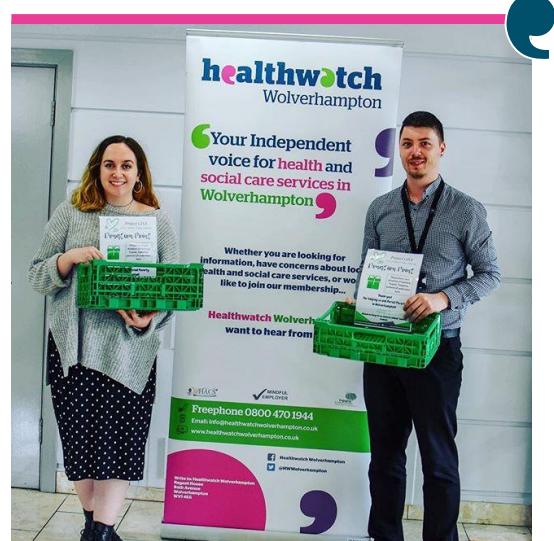
## Project GIVE

In September 2018, we were proud to sign up to a new initiative in Wolverhampton called Project GIVE. Project GIVE aims to tackle the growing problem of period poverty in the city.

495 young girls have admitted to missing entire school days due to their periods and 1 in 7 struggle to afford sanitary products.

After hearing some horrific examples of what young people have been through due to period poverty, Healthwatch Wolverhampton signed up to Project Give and is a designated donation centre, where all donations are welcome.

Staff and volunteers have kindly made donations to help support young people and make sure that no one misses school or has to choose between food and sanitary products.



Receiving our Project GIVE donation packs

## Macmillan coffee morning

On the 28<sup>th</sup> September 2018 we held our very own Macmillan coffee morning to help raise much needed funds for this great cause. We invited our volunteers and staff to bring in cakes and to come along on the day and take part. Everyone had a fantastic day, with plenty of home made cakes and the odd store brought treats, games and conversation.

We raised £70 for Macmillan during the 2 hours we had our table in the reception area of our building. This will go towards providing specialist care and support for those diagnosed with Cancer and their families.



Volunteers raising money during Macmillan coffee morning

## Café Neuro

By working collaboratively with Compton Care and Black Country Neurological Alliance, Café Neuro was set up in Wolverhampton for service users, carers and families to meet other local people and get peer support over a cuppa.

They are able to access information and signposting from local Healthwatch volunteers and staff members and provide feedback on the services they access as part of the treatment for their conditions.

The group sessions take place the third Thursday of every month in the afternoon.

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Café Neuro Group

## Young people

We have worked closely with the City of Wolverhampton College as well as training providers to give young people the opportunity to develop their skills and to get work experience.

Over the course of the year we have supported 15 students from the college and training providers who have given over **650 hours** of work experience between them.

They have supported the role of Healthwatch in a range of ways, including office support and outreach.

We have had requests to take more students as the feedback that has been received has been positive and the students have been talking to their class mates about how they enjoyed their time with us.

One of our students had this to say:

**"I was made to feel welcome and part of the team. It was clear that the staff want to be in the community and understand people's needs and experiences. It was great for me to see what it is like to work in an office."**

*Afolayan*



Wolverhampton College students providing feedback on services

## Diverse communities

We have also been working with the African Caribbean Community Initiative to engage with the community during Carers Week 2018 and to talk to people about their experiences of health and social care. Moreland Trust has also invited us to attend several of their groups, specifically to engage with people from ethnic groups. We have received feedback regarding discrimination towards service users as well as an apprehension to access some services.

During the course of the year we have attended the Wolverhampton LGBT Alliance (Lesbian, Gay, Bisexual and Trans) meetings and historically supported the Pride event which takes place each year. We have listened to the information that the community shares about their experiences of using services as well as looking at national research and available information. We know that as a community, mental health, drug and alcohol misuse, and self-harm are issues which impact the LGBTQ+ community proportionally more than others. Some sexually transmitted infections as well as the rates of suicide attempts in gay men in Wolverhampton is also on the rise.

We have also been working with some Asian ladies groups. They have taken part in surveys for us and we have worked with them to translate the surveys in order to gather their views.

We have incorporated questions into our Enter and View visits specifically asking providers how they create a safe space for different ethnicities, sexual orientations and gender identities. We also ask people if they have felt discriminated against when accessing services. **This has resulted in some providers receiving recommendations for Equality and Diversity training.**

# Your Views on Services

“Our GPs value the close relationship that we have with Healthwatch as they provide us with patient feedback in a timely manner and allow us to work with the patient to resolve any issues or concerns they might have.”

*Practice Manager  
Lee Road Medical Practice*



We have received lots of feedback about health and social care services from service users, their families and carers.

Here are the most common service areas that we have received feedback on in the past year:

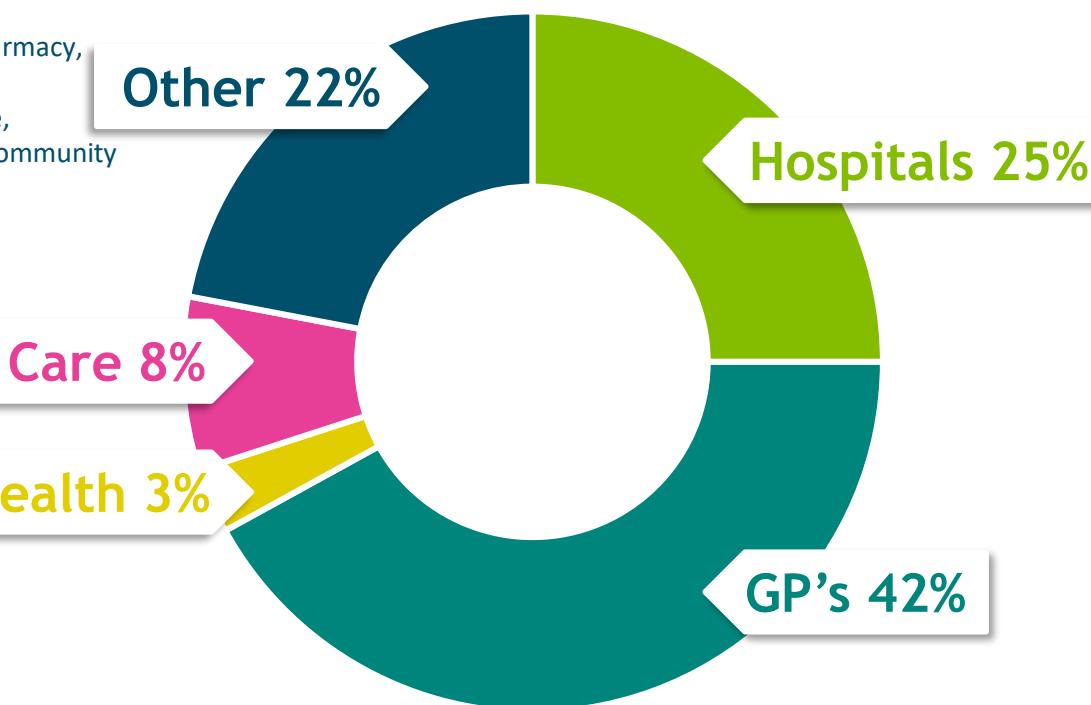
**Other includes:**

Ambulance, Pharmacy,  
District Nurses ,  
Emergency Care,  
Opticians and Community  
Based Services

**Care includes:**

Social care,  
Care Homes,  
Care in own  
homes and  
residential

**Mental Health 3%**



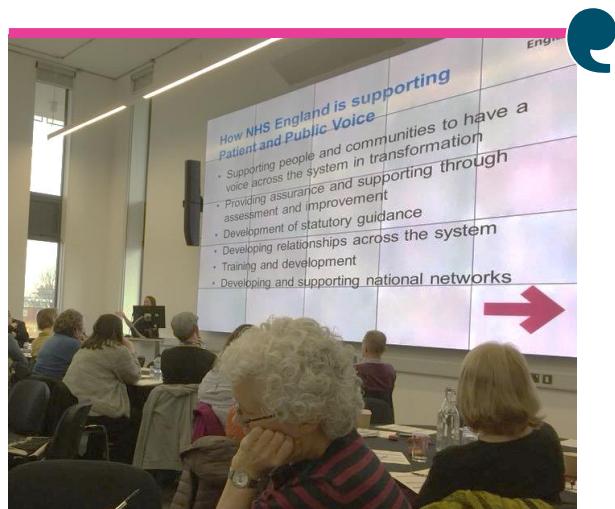
## What do we do with your feedback?

We use your feedback to help make improvements and changes. We do this by: talking to commissioners and managers of services, playing a role in strategic meetings and conducting Enter and View Visits. Some of your feedback is also used to shape pieces of work or further consultations while others have been signposted to our Advocacy services.

The topics of feedback we have received include:

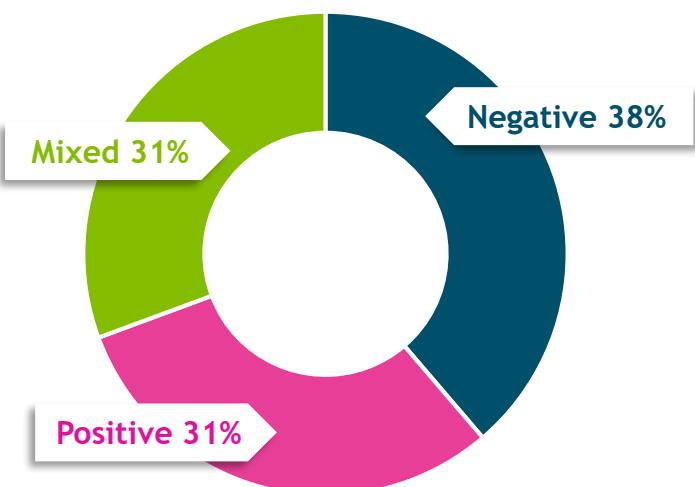
- ❖ Access to services or appointments, particularly the Urgent Care Centre and GP's
- ❖ Communication between services and service users
- ❖ Discharge from hospital

If you would like to talk to us about the health and social care services you use and help to shape the local services in your communities, we would love to hear from you; please contact us.



## Themes of your feedback

Over the last twelve months we have received over **240** general pieces of feedback about health and social care services across Wolverhampton. Each piece of feedback we receive has a theme, whether it be positive, negative or mixed. Receiving these experiences is a vital part of what we do as it helps to demonstrate when a service is working well or not so well and can aid us to make a decision about how we might initiate changes. Examples of the feedback received can be found below:



### GP Surgeries

*"My GP treats me with respect, and it feels like he really knows me"*

*"I usually have issues getting an appointment with my GP so I go to the Urgent Care Centre"*

*"I don't have a named GP and am always seen by a locum doctor. It feels like no one wants to take responsibility for my care"*



### Hospitals

*"I had an emergency stay at New Cross Hospital and the care was really good"*

*"Been looked after well at the Heart and Lung Centre"*

*"I've been battling to get my family member discharged, caused by delays in social care"*

*"I waited three hours past my scheduled appointment to be told I couldn't be seen"*

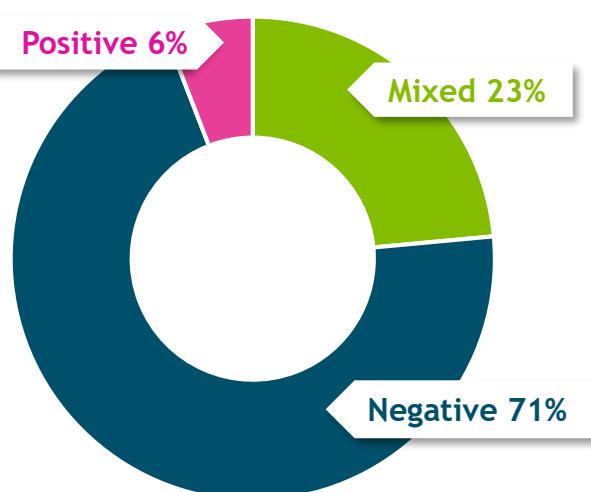


### Social Care

*"I'm not getting help from my support worker to help fill out forms that would help me get access to support"*

*"I can't speak highly enough about the staff, the level of care my mom gets is second to none"*

*"I have a new carer coming in every day. The manager told me there is a staffing issue"*



# Helping you find the answers

The person was pleased to have finally been pointed in the right direction and thanked us for our time.

*Service user*



## Signposting and advice

Throughout the year we have received many phone calls from people that needed some help finding the right services for them or just felt a little lost.

In December we received a call from a member of the public who could not seem to find the right advice to help them stop smoking and to find out if they were eligible for free prescriptions.

The person felt that the GP did not provide much support and that Wolverhampton Clinical Commissioning Group did not seem to have the answers either.

Following a phone call with us, the person was advised to go to the Pharmacy as they can provide advice relating to both of these topics, and to look at the “Click before you tick” website, which allows you to check your eligibility for free prescriptions.

**The person was pleased to have finally been pointed in the right direction and thanked us for our time.**

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“Representatives from Healthwatch Wolverhampton came along to one of our Coffee Mornings to talk about the work of Healthwatch and to listen to peoples experience, in particular the experience of Health and Social Care services that parents of children with Autism and Learning Difficulties have.

Many parents spoke of their frustrations when they had to take their child to Accident and Emergency and they also made suggestions about how to improve provision.

It was explained at the coffee morning that Healthwatch would raise these concerns with the relevant agencies and was able to signpost some of the parents to sources of help and support.”

*Melanie Heywood*

*Family liaison Officer, Tettenhall Wood School*

In August 2018 we were contacted by a service user who wanted support making a complaint, independently of the Patient Experience Team or their GP as a complaint had already been made but it was just being “passed from pillar to post and no one is taking responsibility”.

The person was receiving treatment for a condition and after several months they were told that they should have been having pain relief treatment instead and that a referral would be made to the GP.

After several months, there had been no further contact so the person called the GP to investigate. The referral had been received some time before but had not been processed which triggered their complaint.

The person had been waiting longer than necessary, and the situation was having an impact on their mental and physical health.

**A referral was made to the Advocacy Service who was able to support them in making a complaint and getting the matter resolved.**

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Healthwatch Wolverhampton received a referral from the advocacy service regarding a resident at a care home who did not want to make a complaint but felt that there were a number of issues at the home that needed to be looked at. This was specifically around the level of care provided by the staff and their willingness to help.

An Enter and View visit was carried out and the Authorised Representatives found that other residents at the home also had similar experiences.

**The home received a number of recommendations from us and during a follow up conversation it would appear that a number of these have been taken on board**

# Complaints and Advocacy

**“I would not have had the will to go through with making a complaint on my own as it was very daunting. My advocate gave me confidence”**

*Advocate service user*



# Complaints and Advocacy

Wolverhampton Health Advocacy Complaints Service (WHACS) supported **81** Wolverhampton residents to make a formal NHS complaint in 2018/2019.

The majority of referrals received were self-referrals and most complainants contacted the advocacy service using the freephone number. We also received self-referrals via email.

An increasing number of referrals came from Healthwatch Wolverhampton, who had identified people who may benefit from WHACS support as well as from enquiries made to Healthwatch Wolverhampton's helpline.

WHACS promotes self-advocacy to develop self confidence and self-empowerment. We were able to support an average of 30% of new complainants to self-advocate by providing information about the NHS complaints procedure in the form of our Self-Help Information Pack which is sent to all new complainants upon receipt of referral.

70% of complainants were provided with intensive advocacy support where the advocate provided one to one support according to the complainants needs.

Themes included:

- ❖ Quality of care and treatment
- ❖ Access to Services
- ❖ Diagnosis
- ❖ Delays / Cancellations

The majority of complaints are resolved through direct communication with the service provider and the outcomes achieved include:

- ❖ An apology
- ❖ An explanation
- ❖ A change to process/procedures

Sometimes the complainant is not able to resolve the complaint directly with the service provider, and in these cases the advocate will support the complainant to refer the complaint to the Parliamentary Health Service Ombudsman (PHSO). We supported **9** complainants to refer their complaint to the PHSO in 2018/19.



Judith Stroud  
Complaints Advocate

## What our clients say

Complainants have the opportunity to provide feedback on the service they have received from their advocate as this helps us to monitor and improve our service.

During 2018/19 feedback included the following comments:

**“A very helpful service - please continue to provide this to the public. It would be very difficult to get your voice heard without more people like my advocate”**

**“My advocate explained my options throughout the complaints process”**

**“I was able to make my complaint after talking to my advocate. She was always there if I had any questions”**

**“I would not have had the will to go through with making a complaint on my own as it was very daunting. My advocate gave me confidence”**

**“My advocate supported me and always responded to when I needed to speak to her”**

## Case study

### Intensive advocacy support

Y's father died within one hour of being discharged from Accident and Emergency after being admitted with chest pains and shortness of breath. He was discharged with medication following a diagnosis of constipation. He sadly died shortly after arriving home from hospital.

Following the receipt of Y's complaint, Royal Wolverhampton NHS Trust carried out a Root Cause Analysis and it was identified that:

**“The clinical information provided to A&E by the ambulance crew was not appropriately taken into account by the A&E medical team”.**

The response stated that the Emergency Department had changed its processes so that documentation from an ambulance crew is readily available to the medical team.

Y was not satisfied with the response and their advocate supported them to write back to the Trust. Y was invited to meet with the Trust and their advocate helped them to prepare their questions for the meeting and accompanied them to the meeting with the Trust. The consultant agreed that Y's father should not have been discharged from A&E and that medical staff did not pay enough attention to his heart condition.

The notes of the meeting provided by the hospital, did not accurately reflect the discussions that took place during the meeting and Y's advocate supported them to write to the Trust to request a more accurate account of the discussions which took place. The Trust responded and outlined changes that were to be implemented in light of the complaint.

Y is currently considering their options and has been signposted to AvMA (Action for Victims of Medical Accidents) for medico-legal advice.

# Enter and View

## Enter and View Report

Anville Court Nursing Home  
Unannounced Visit  
19<sup>th</sup> July 2018

“As an Authorised Representative I have been able to gather the views of patients in GP Practices, hospitals and of residents in Care Homes....

Healthwatch has given me the opportunity to utilise my skills, experience and knowledge in a positive way”

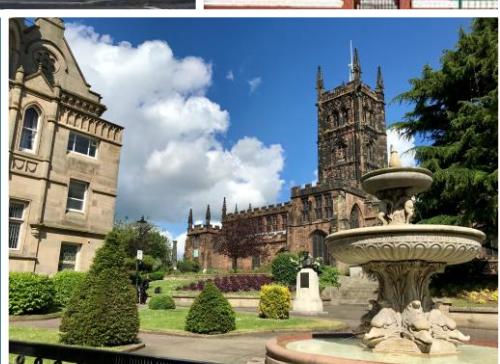
*Dana Tooby*

*Healthwatch Volunteer, Authorised Representative and Board member*



## Enter and View Report

Bilton Health Centre - Dr Mudigonda  
Unannounced Visit  
11<sup>th</sup> February 2019



# Enter and View

Enter and View is not an inspection but a statutory duty that Healthwatch carries out to observe services being delivered and to gather service user feedback.

It is just one way for us to better understand the service user experience whilst they are directly using the service. Our Enter and View visits are carried out by staff and volunteers known as Authorised Representatives.

Services can be selected for Enter and View for a number of reasons, for example;

- ❖ To respond to intelligence reported to Healthwatch by service users, Care Quality Commission (CQC) or Wolverhampton Clinical Commissioning Group (CCG)
- ❖ To feed in to a larger piece of work
- ❖ To observe a service that has received a poor CQC report

Once the visit is planned and depending on the types of intelligence, it is then decided whether that visit will be announced, unannounced or semi-announced. During a visit we engage with service users, their families, carers and the staff that deliver the service.

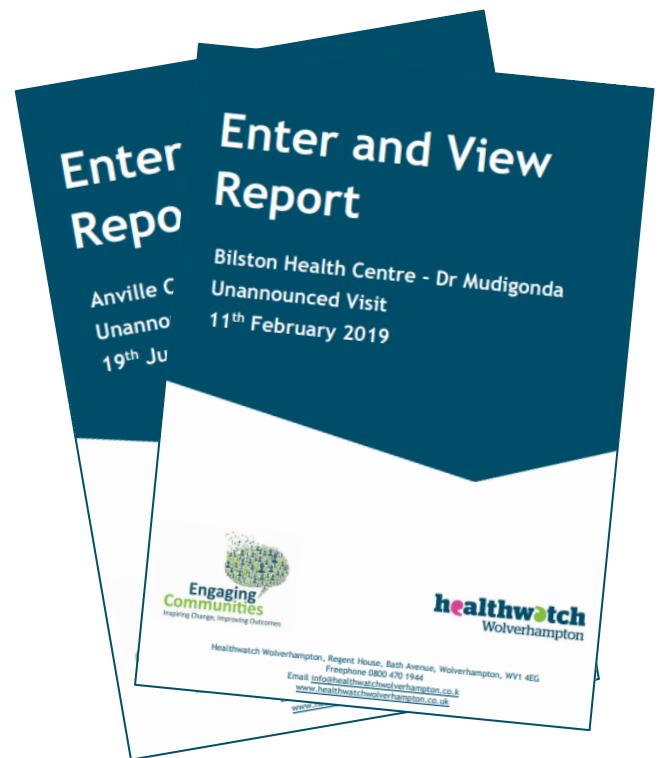
## Enter and View visits carried out in 2018/19:

- ❖ Bilston Health Centre - Dr Mudigonda
- ❖ Coalway Road GP Practice
- ❖ Tudor Medical Centre
- ❖ Low Hill GP Practice
- ❖ New Cross Hospital: Ward A12
- ❖ New Cross Hospital: Ward A14
- ❖ New Cross Hospital: Eye Infirmary
- ❖ Aldergrove Manor Care Home
- ❖ Anville Court Nursing Home

The feedback that is received and the observations made are put into a report with any recommendations that we make.

These reports are then sent to the relevant organisations including: the local authority, CQC, WCCG, Healthwatch England, NHS England, local councillors and the provider and published on our website.

We have spent some time working with volunteers to ensure that the process is as simple as possible and changed forms used when conducting visits. We have also aligned Enter and View to the eight principles of Healthwatch asking a range of questions linked to each principle (see page 30).



- ❖ Probert Court Nursing Home (joint visit with Wolverhampton CCG)
- ❖ Sycamores Nursing Home
- ❖ Mill House Care Home
- ❖ Wrottersley Park House Care Home
- ❖ Bentley Court Care Home

# Our Authorised Representatives

Enter and View visits would not be possible without our team of dedicated volunteers and staff known as Authorised Representatives.

Authorised Representatives are volunteers, and/or Healthwatch staff who have been trained to talk to service users and observe services being delivered. They are not medically trained or trained in health and social care but they help to provide a laypersons perspective of services that are being delivered in Wolverhampton.

Each Authorised Representative brings with them their own set of skills and knowledge which has helped us to shape and adapt our Enter and View visits over the past 12 months. We have an ongoing recruitment and training opportunity for Authorised Representatives.

During 2018/19 we undertook 14 Enter and View visits at a range of settings including GP practices, nursing and residential homes as well as wards at New Cross Hospital.

We would like to thank all of our Authorised Representatives for their time, hard work and dedication to our Enter and View programme.

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## Healthwatch Eight Principles

Healthwatch has a set of eight key principles that underline your rights as service users as well as guides us in the work that we carry out on your behalf.

- ❖ Healthy Environment
  - ❖ Essential Services
  - ❖ Access
  - ❖ Safe, Dignified and Quality Service
  - ❖ Information and education
  - ❖ Choice
  - ❖ Being Listened To
  - ❖ Being Involved
- 

## Our Authorised Representatives are:

- ❖ Anita Kainth
- ❖ Louise Omekoko
- ❖ Ashley Lovell
- ❖ Maggie Makombe
- ❖ Anu Sandu
- ❖ Marlene Lambeth
- ❖ Beverly Davis
- ❖ Mary Brannac
- ❖ Dana Tooby
- ❖ Matthias Katanga
- ❖ Donald McIntosh
- ❖ Pat Roberts
- ❖ Emily Lovell
- ❖ Raj Sandhu
- ❖ Tina Richardson
- ❖ Greg Gill
- ❖ Jane Emery
- ❖ Janice Edwards
- ❖ Judith Stroud
- ❖ Kerry Southall
- ❖ Kirpal Bilkhu
- ❖ Rasham Gill
- ❖ Roger Thompson
- ❖ Rose Urkovskis

## Coalway Road GP Practice

This unannounced visit took place on 14th January 2019 due to the CQC's inspection report which rated the service as requiring improvement. We were also aware that a new manager had recently started at the practice.

The majority of patients that engaged with the Authorised Representatives felt that they were able to get appointments when they needed them and that they had “noticed an improvement in the service since the new practice manager had started in July”.

The practice actively signposted patients to additional services such as Social Prescribing (connecting people in the community to support their wellbeing). They also signposted to Thrive into Work (supporting people with long term health conditions back into work).

All of the patients that took part in the visit reported that they felt safe at the practice and that they didn't feel discriminated against in any way. Some patients told us that their family had received support in accessing additional services such as mental health support.

At the time of our visit the staff at the practice were not dementia trained, however, this was something that the manager was keen on bringing to the practice as they wished to deliver a dementia friendly service.

There was a mixed response from patients in regard to being listened to. Patients felt able to ask questions if they didn't understand something but not everyone knew how to make a complaint. Some of the patients felt that their concerns were taken seriously, while others did not.

We did notice surveys available in the reception area but some patients told us they were regular visitors and had never been asked to take part.

There was no feedback mechanism in place; this was discussed with the manager during the visit, who explained that they didn't have a way to communicate any actions or respond to patient feedback.

It was advised during the visit that a “You Said, We Did” should be put in place and the manager was open to this idea.

Our recommendations included:

- ❖ Take steps to increase engagement with patients in order to gain an understanding of their needs
- ❖ Ensure information about patient involvement is clear and visible
- ❖ Implement a “You Said, We Did” to provide feedback to patients

Since our visit a “You Said, We Did” notice has been implemented.



Coalway Road GP Practice

## Aldergrove Manor Care Home

Aldergrove Manor was visited on Saturday 26<sup>th</sup> January 2019. On observation the home seemed clean and had a good friendly and homely atmosphere, with all staff and residents who engaged with Authorised Representatives speaking positively about the home.

From the outset, it was clear that residents choice was promoted throughout the home, from food to activities. A variety of activities were on offer, including Wednesday designated as a "pampering day".

Staff told Authorised Representatives that activities are chosen for residents based on their likes and hobbies and the things they enjoyed when they were younger. The home appeared to be receptive to residents input and feedback and were in the midst of trialing changes instigated by residents.

Recommendations included:

- ❖ Introducing a welcome information pack to help new residents settle in
- ❖ All staff to wear name/identification badges
- ❖ Backup electronic copies of key information as most of the information is kept in paper form only
- ❖ Introduce signage outside of the home to make it easier for visitors to find

## Providers Response

"I felt the visit went well. The team visiting was very knowledgeable and approachable. The visit was not threatening in any way.

They were very receptive of all our improvements and projects which we have been involved in. I did inform the visitors that Select as a company were in the process of helping us with a welcome pack and was a work in progress.

Regarding name badges we are looking into ordering some different means of identifying staff. Electronic backup is being looked into by Select to ensure records are safe. Maintenance are looking into new signage for the building."

*Home Manager*



Aldergrove Manor Care Home

## New Cross Hospital: Ward A12

Ward A12 (a female general surgery ward) was visited on Saturday 9<sup>th</sup> November 2018 following feedback we had received from service users. It was decided that we would conduct an unannounced visit on this occasion.

The ward environment was well maintained and clean but there were some unpleasant smells. We had no concerns about the overall environment or the maintenance of the equipment.

We did observe a nurse and a student nurse changing bedding without wearing aprons and without using any gloves which did cause some concern around cross infection.

It was clear during our visit that staff were very responsive to patients despite the ward being busy. One nurse did stop her conversation with Authorised Representatives in order to respond to a patient, which was great to see as this is not always the case.

It was noted how highly patients talked about the staff. Overall, patients felt safe and were treated with respect and dignity.

The recommendations included:

- ❖ Ensure that all lighting is in full working condition
- ❖ Ensure that all staff including student nurses are aware of infection control procedures and the importance of Personal Protective Equipment (PPE)
- ❖ Introduce a chart identifying the different uniforms



New Cross Hospital

## Providers Response

The provider was given the opportunity to comment on the report, however no response was received.



# Our Volunteers



“big thank you to you and your team and all the volunteers for the amazing work you did for Antibiotics week. The Facebook posts you did were fantastic!”

Riva  
Prescribing Support Team  
Feedback following Antibiotics Week



At Healthwatch Wolverhampton we wouldn't have been able to encourage improvements to the health and social care services in our community without our dedicated volunteers; our volunteers are invaluable to our work.

### What our volunteers do:

- ❖ Raise awareness of the work we do in the community by supporting the community outreach lead.
- ❖ Visit services on Enter and View visits to make sure they are meeting people's needs.
- ❖ Supporting our day to day running in the office
- ❖ Collect people's views and experiences of health and social care services which we use to guide further work and reports

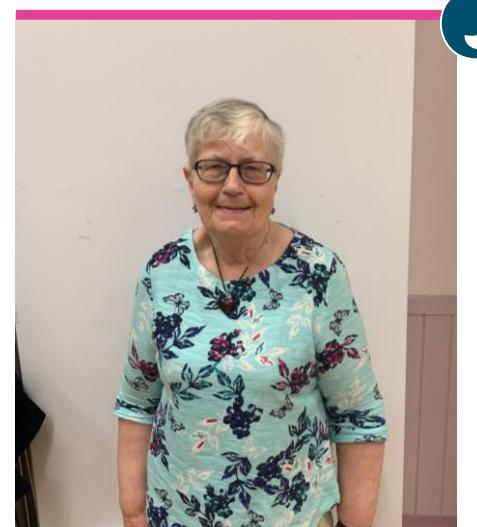


"I started to volunteer after I had a stroke and could not work anymore. I joined the Patient Participation Group at my doctor's office and found out about Healthwatch through them."

I have always been interested in health issues and want to be involved. Volunteering has been very stimulating for me and has helped in recovering from my stroke.

With Enter and View I am involved in going out and visiting various institutions and writing reports. It is very interesting to learn about the services that the NHS provide and I also use my skills from my previous profession. It is challenging but I am out and about meeting new people."

*Mary*



"I started in November 2018 to do 270 hours work experience. The main thing I wanted to do was develop my confidence. I slowly gained confidence by doing different things such as; asking questions, talking on the phone, going out to GPs and hospital and going to different events etc."

I finished the hours required for work experience in April 2019 and decided to continue volunteering at Healthwatch. This helped me to find out what was best for me to do next.

Overall, Healthwatch was a great place to be at because I met nice people who helped me to gain confidence and learn what a working environment is. Thank you."

*Andrada*

"I was a member of LINK which evolved to become Healthwatch and I am now a member of the Healthwatch Advisory Board.

I have had various roles, such as supporting some of the community engagement events. This often also involves collecting information from people about specific health issues and involves: focus groups for young first time mothers' experiencing social isolation, visiting hospital wards to talk to patients about the discharge process or listening to parents of children who have special needs about their experience of Accident to Emergency provision. It all helps paint a picture of local services.



As an Enter and View Authorised Representative I have been able to gather the views of patients in GP practices, hospitals and of residents in care homes.

I have represented Healthwatch at various health forums including Stroke, Frailty and End of Life - and as a member of Health Scrutiny I have been part of the decision making process at a strategic level.

Healthwatch has given me the opportunity to utilise my skills, experience and knowledge in a positive way.

This all sounds very dry; the reality is that I really enjoy being part of Healthwatch- I've met some great people and I have lots of fun too!"

*Dana*

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"I am a member of the Advisory board of Healthwatch Wolverhampton. I help as a volunteer by helping to promote Healthwatch at events around Wolverhampton. This includes surveys, promotions, complaints which we use as feedback to the service providers.

I have always been interested in health issues and I enjoy engaging with people and listening to their views either good or bad. Being part of Healthwatch is so gratifying and I also enjoy the involvement & friendship. "

*Jane*



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"First of all I was very impressed with the initial contact I had from Healthwatch Wolverhampton. Thank you to the staff - interview and induction was very professional. I chose Healthwatch because I worked in a GP Practice for 9 years and I also have a HR background, with skills I could potentially bring to Healthwatch."

*Josie*

# Meet the team

## Your local Healthwatch team



**Tracy Cresswell**  
Manager



**Ashley Lovell**  
Engagement and  
Information Lead  
(started May 2018)



**Emily Lovell**  
Engagement and  
Information Lead  
(started March 2019)



**Rasham Gill**  
Community Outreach  
Lead



**Charlotte Williams**  
Community Outreach  
Lead  
(November 2018 - January 2019)

# Meet the Board

## Healthwatch Wolverhampton Advisory Board



**Sheila Gill**  
Chair



**Dana Tooby**



**Rose Urkoskis**  
(started March 2018)



**David Bhutan**  
(started July 2018)



**Maggie Makome**  
(started March 2018)



**Jane Emery**

# Message from our Manager

As you can see this year has been a busy one, we have welcomed two new staff members to the team and our contract has been extended to 31st March 2021.

We worked on a number of priorities that had been identified by the general public; from simply carrying out a mapping exercise of services to a survey of over 500 responses around communication from their GP practices.

One of our biggest achievements this year has been working together with stakeholders to ensure the seldom heard voice is being listened to and actions have been put in place to support them. This has resulted in a relationship that has been built up with the Deaf and hearing-impaired community.

Looking ahead at next year some of the challenges will be the changing landscape in Health and Social Care and how the Primary Care Networks will develop and improve patient experience.

The NHS Long Term Plan will be part of the work that we will be focusing on alongside our Black Country Healthwatch colleagues and Black Country Sustainable Transformation Plan (STP) partners.

Our priorities for 2019/2020 build on the intelligence that we have received throughout this year, they are:

- ❖ **Isolation and loneliness** - Phase 2 will focus on over 55's.
- ❖ **Maternity** - Healthwatch will focus on understanding why there has been no change to the experience received from moms during and after birth.
- ❖ **Cervical Cancer** - Healthwatch will focus on Cervical cancer to understand why the

uptake of smear tests is not good in Wolverhampton.

- ❖ **Mortality** - Wolverhampton is an outlier for above average deaths in the city, Healthwatch want to understand how families are being involved.

**Thank You** to everyone that is helping us put people at the heart of health and social care including:

- ❖ Members of the public who shared their views and experience with us
- ❖ All of our amazing staff and volunteers
- ❖ All the partners and stakeholders who we have worked with and continue to work with

I would like to personally like to thank:

- ❖ Wolverhampton College for the wonderful students that have carried out their work experience with us.
- ❖ Juniper Training for the challenging students that we have had and worked with and seen them flourish
- ❖ Zebra who we have worked with together to ensure that the Deaf and hearing-impaired community was given a voice.



**Tracy Cresswell**  
Healthwatch Wolverhampton Manager

# Our finances

Income	£
Funding from the Local Authority to deliver Healthwatch	194,289
Additional Income	1,593
<b>Total</b>	<b>195,882</b>
Expenditure	£
Staffing	137,158
Operational	35,744
Running Costs	15,597
<b>Total</b>	<b>188,499</b>



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# Health Scrutiny Panel

7<sup>Th</sup> November 2019

**Report title** Development of the Medical Examiner Role and on site Registrar

**Report of:** Dr Jonathan Odum, Medical Director  
Dr Mike Norell, Lead Medical Examiner

**Portfolio** Public Health and Wellbeing

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**Recommendation(s) for action or decision:**

The Health Scrutiny Panel is recommended to:

Note the report

## Introduction

- 1.1 The Royal Wolverhampton NHS Trust (RWT) has a clear strategy to learn from deaths that occur whilst the patient is under the care of the organisation. A key part of this system is the development of the Medical Examiner office with its close links with the coroner's office and the commitment to provide the opportunity to hear the experience of bereaved families.

Alongside this development came the provision of a new capital development, the Bereavement Centre, and this provided the opportunity for the registrar to be on site to work alongside RWT's bereavement team.

This report provides an update on the impact of these initiatives so far.

## 2.0 Background

- 2.1 RWT developed a Bereavement Centre in a vacant area of the Urgent and Emergency Care Centre and this opened in January 2019. The Bereavement centre is staffed by administrative officers, medical examiners, a bereavement nurse and the city council Registrar. The new centre allows bereaved families to attend, pick up the death certificate, speak with a medical/nursing member of staff if they want to and register the death at the same appointment.
- 2.2 In January 2019 the Trust was one of the first organisations in the country to introduce the role of the Medical Examiner (ME). The introduction of this role is a key part of the regime set out in the Coroners and Justice Act 2009 covering all deaths within England and Wales. In April 2019 a national Medical Examiner was appointed and the expectation then was that the position of Trust based medical examiners would be rolled-out albeit via a non-statutory scheme. It is envisaged that the scheme will cover all hospitals by the end of March 2020 and that there will be a move by the Government towards placing the scheme on a statutory footing, and then a further development of the statutory scheme to cover deaths within hospitals and within the community by the end of March 2021. RWT has been at the forefront of the scheme development, sharing experience with other organisations as they develop and has been involved in the selection and appointment of regional Medical Examiners
- 2.3 Medical Examiners are senior doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification.

The purpose of the medical examiner system is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- Ensure the appropriate direction of deaths to the coroner
- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased

- Improve the quality of death certification
- 2.4 **Scrutiny:** The introduction of the Medical Examiners role now means that cases where the death occurred within the hospital can be scrutinised by an independent medical colleague within days of the death. From a starting position of 29%, approximately 60% of cases are now scrutinised each month. Whilst progress has been made, the Trust's aim is to achieve over 90%. There are currently issues that require resolution to reach this target and these include the ability to provide support for those deaths that occur in the Emergency Department, often out of day time hours and an improvement in the capability to cover for each ME at times of annual leave. This may require the appointment of Medical Officers to support the MEs and improve capacity.

Month	% of total deaths scrutinised by Medical Examiners	% of total deaths referred for further review (from July 19 to Mortality Reviewers)
January	29%	17%
February	46%	17%
March	58%	14%
April	55%	20%
May	60%	22%
June	64%	23%
July	62%	21%
August	52%	16%

The Trust's policy, in line with national guidance, is that where potential areas of concern with care are picked up at scrutiny, the Medical Examiners will refer cases on for more detailed review. From July '19 this is to a team of Mortality Reviewers in the Trust. This includes cases where relatives have raised issues as well as a group of conditions where mandatory referral is required i.e. patients who die following an elective procedure, children, patients with specific mental health conditions and those with learning disabilities.

These reviews allow the organisation to record good and poor practice. The governance system in place then mandates that individual results are shared with directorate teams and thematic presentations shared at Divisional and Trust Board level. Note that these learning points do not necessarily mean that the care provided (or omitted) has contributed to the death, but that there are areas where care can be improved to enhance overall experience.

Examples of learning that have been picked up include areas of good and less good practice around End of life care, omissions of communication and delays in recognising deterioration.

- 2.5 Direction of Deaths to the Coroner: As part of the process, the Notification of Deaths Regulations 2019 came into force on 1st October. The Regulations state that a registered medical practitioner must notify the relevant senior coroner of a person's death in certain types of cases. Hitherto there have been no regulations and circumstances of reporting have varied across coroner areas. The presence of a team of Medical Examiners with expertise in the appropriateness of referral ensures that the Trust's medical teams are guided to make the referrals where necessary.
- 2.6 Bereaved Families: The role of the ME requires them to make contact with the bereaved family in order to hear their experience and to use this feedback in order to inform the scrutiny process. Alongside the ME, the Trust appointed in June 2019, a Bereavement Nurse who provides a further source of contact for families where necessary and signposts to support services where appropriate.

Thus far, informal feedback from discussions between the ME and the bereaved has been very positive; the family will frequently praise the quality of care and attention received by the patient. Issues that have generated less positive feedback typically include poor communication resulting from the next of kin being provided with differing messages regarding their loved-one's management. Similarly, another typical response has been that the family of a deteriorating patient did not appreciate that he or she was so close to death as turned out to be the case. These occasional concerns are rarely felt to be sufficient to prompt the bereaved to complain through PALS, and they are included often as an afterthought and then only for "completeness". The MEs nevertheless will offer to feedback those comments to the medical teams and this is also much appreciated.

As well as the verbal feedback which informs the scrutiny process, families are also encouraged to provide written feedback on both the Bereavement office processes and care provided to their family member in the last days of life. Feedback from families regarding the process has largely been positive and appreciative of the time made by the Trust to hear their views. Of those who completed the survey 95% of families rated the Bereavement office service good or very good. The data provided on end of life care is reviewed at the End of Life Steering Group and informs the focus of education for nursing and medical staff, including further use of the SWAN suite and the importance of consistent communication between staff and families.

- 2.7 **Quality of Death Certification:** The new system requires that the death certificate should not be written without the medical team involved in the case discussing the case with the ME. Prior to this it was often a junior member of the medical team alone who completed the death certificate and this is recognised nationally. Lack of experience will undoubtedly have hampered the accuracy of the certificate. One to one discussion with the ME is now required before completion and training in the death certification process from the ME is now included at junior doctor induction. Both of these steps will enhance the accuracy of the data entered on the certificate, which provides both information for individual families and national data bases on cause of death.

2.8 Registration of death should be within 5 days. There is no doubt that delays in completion of certification have contributed to these delays, as has the requirement for families to attend the hospital to collect the certificate and then the civic centre to register. These delays are frustrating and upsetting for families and administrative staff. Wolverhampton has been amongst the poorest performers against the 5 day registration target in the West Midlands, historically only completing 65-75% within the time frame. Since summer 2019 Wolverhampton has begun to achieve 85-95%, undoubtedly influenced by the focus on junior doctors to complete the certificate in a timely fashion and the provision of one stop registrar facilities on site.

2.9 **Future Plans:** These include:

Focus on improving the scrutiny rate of cases by the Medical Examiner from 60% to over 90% of cases.

Engage with other agencies, including Primary Care and WMAS to develop a system of scrutiny which takes a broader view of care provided beyond the hospital site.

### 3.0 Impact on Health and Wellbeing Strategy Board Priorities

Which of the following top five priorities identified by the Health and Wellbeing Board will this report contribute towards achieving?

- |  |                          |
|--|--------------------------|
| Wider Determinants of Health                     | <input type="checkbox"/> |
| Alcohol and Drugs                                | <input type="checkbox"/> |
| Dementia (early diagnosis)                       | <input type="checkbox"/> |
| Mental Health (Diagnosis and Early Intervention) | <input type="checkbox"/> |
| Urgent Care (Improving and Simplifying)          | x                        |

### 4.0 Decision/Supporting Information (including options)

### 5.0 Implications

Please detail any known implications in relation to this report:

- Financial implications

There may be the requirement to employ more Medical Examiner sessions and/or Medical Officers in order to achieve scrutiny in more than 90% of cases.

- Legal implications

There is a statutory obligation to refer certain cases to the Coroner, and the presence of the ME system provides the Trust with the assurance that it has the expertise to identify those cases in a consistent fashion

Whilst the ME system itself is not statutory at the moment there is an expectation that this will become so for hospital sites by March 2020 and for other organisations by March 2021.

#### Equalities implications

There is the requirement to ensure that where early release for burial or cremation is required, that the case is scrutinised in a timely fashion. The risk of not meeting this timescale but still ensuring scrutiny is higher at weekends.

## 6.0 Schedule of background papers

- 6.1 The background papers relating to this report can be inspected by contacting the report writer:

Dr Jonathan Odum  
Medical Director  
Royal Wolverhampton NHS Trust  
Direct line 01902 695898  
[jonathan.odum@nhs.net](mailto:jonathan.odum@nhs.net)

Further information can be found at <https://www.england.nhs.uk/wp-content/uploads/2>

## Scrutiny Work Programme

### Health Scrutiny Panel

The Panel will have responsibility for Scrutiny functions as they relate to: -

- All health-related issues, including liaison with NHS Trusts, Clinical Commissioning Groups, Health and Wellbeing Board and Healthwatch.
- All functions of the Council contained in the National Health Service Act 2006, to all regulations and directions made under the Health and Social Care Act 2001, the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002,
- The Health and Social Care Act 2012 and related regulations.
- Reports and recommendations to relevant NHS bodies, relevant health service providers, the Secretary of State or Regulators.
- Initiating the response to any formal consultation undertaken by relevant NHS Trusts and Clinical Commissioning Groups or other health providers or commissioners on any substantial development or variation in services.
- Participating with other relevant neighbouring local authorities in any joint scrutiny arrangements of NHS Trusts providing cross border services.
- Decisions made by or actions of the Health and Wellbeing Board.
- Public Health – Intelligence and Evidence
- Public Health – Health Protection and NHS Facing
- Public Health - Transformation
- Public Health – Commissioning
- Healthier City
- Mental Health
- Commissioning Mental Health and Disability
- HeadStart Programme

Date of Meeting	Item Description	Lead Report Author	Notes
7 November 2019	<ul style="list-style-type: none"> <li>• GP appointment waiting times – involve Wolverhampton Healthwatch – GP Communication</li> <li>• CCG Annual Report</li> <li>• Draft Budget</li> <li>• Public Health Annual Report</li> <li>• Healthwatch Annual Report</li> <li>• Review of the impact of the new Medical Examiner Role and the Registrar's Office at New cross Hospital</li> </ul>	CCG – Helen Hibbs  Steven Marshall  Public Health – John Denley  Tracey Cresswell  Dr Odum & Dr Norell	
16 January 2020	<ul style="list-style-type: none"> <li>• Reconfiguration of hyper acute and acute stroke services</li> <li>• Cancer Screening</li> <li>• Accident and Emergency</li> <li>• STP (Sustainability and Transformation Plans)</li> </ul>	CCG / Royal Wolverhampton NHS Trust  Royal Wolverhampton NHS Trust / Public Health  Royal Wolverhampton NHS Trust / CCG  Helen Hibbs	

	<ul style="list-style-type: none"> <li>• Blakenhall Dementia Day Services? (Provisional)</li> </ul>	Tom Denham	
5 March 2020	<ul style="list-style-type: none"> <li>• Mortality Statistics</li> <li>• Patient Participation Groups</li> <li>• Pharmaceutical Ordering (Provisional)</li> <li>• West Midlands Ambulance</li> <li>• Maternity Services – Quality Assurance</li> </ul>	<p>Royal Wolverhampton NHS Trust</p> <p>Royal Wolverhampton NHS Trust</p>	<p>To address priorities identified in the Quality accounts and in particularly those on Maternity Care in the pre-hospital environment.</p>

**Potential Future Items: -**

1. Black Country Partnership NHS Foundation Trust Merger – Possible an informal meeting will be arranged
2. June 2020 – Review of the new Patient Experience, Engagement and Public Involvement Strategy.
3. Healthy Child Programme

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