ANNUAL REPORT

2018/19

NHS

Wolverhampton

Clinical Commissioning Group

Contents

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.

2018/19 Performance	Target	Actual
Statutory duties:		
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
Non-statutory duties:		
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.

	Opening £ 'm	Closing £'m	Increase £'m
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
Total	**412.638**	**424.036**	**11.398**

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.

	Annual Plan £m	Actual £m	Variance under/(over) £m	Variance %
Healthcare Allocations	408.49	408.49		
Running Cost Allocation	5.56	5.56		
Brought Forward Allocation	9.99	9.99		
Total Allocations	**424.04**	**424.04**		
Expenditure				
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%
Total Expenditure	**414.05**	**414.01**	0.04	0.0%
Revised Target (NHSE)	9.99	9.99	0.00	
Underspend in excess of Revised Targe	0.00	0.04	0.04	

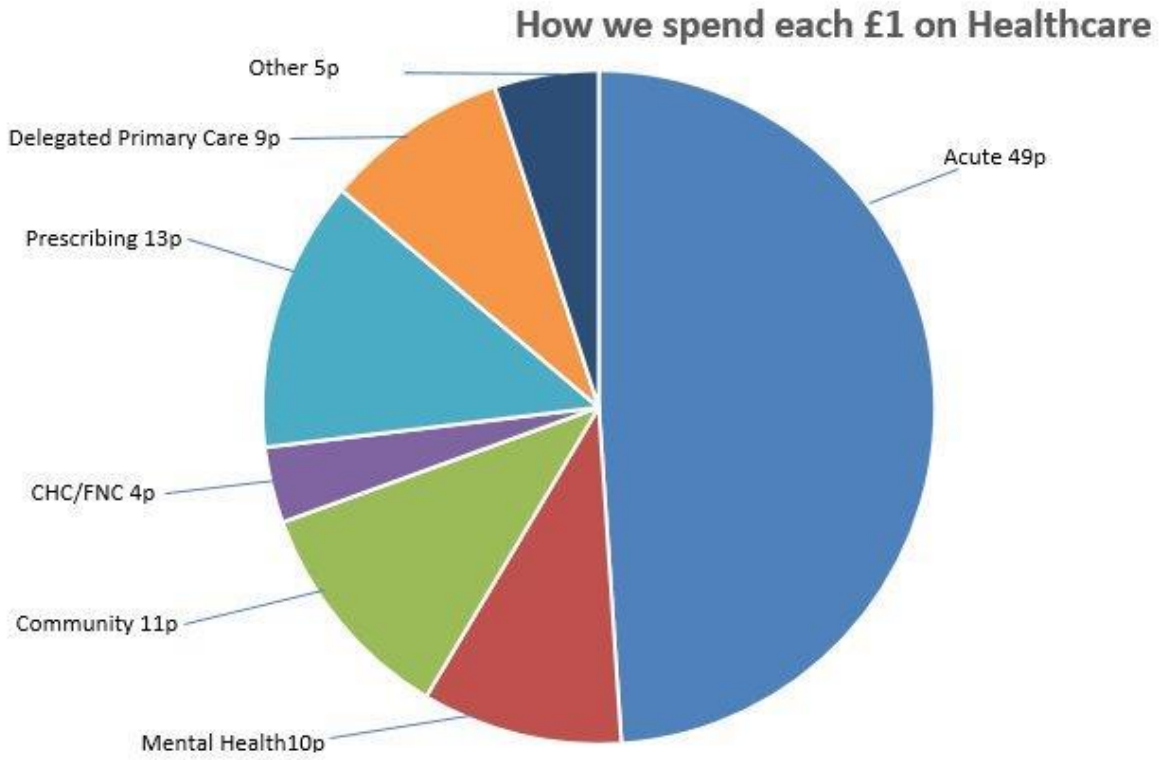
During 2018/19 the CCG has developed and operated an Aligned Incentives Contract, AIC, with its main Acute and Community provider, RWT. This development represents a significant step towards working as a healthcare system across Wolverhampton, recognising risks associated with transformation and developing 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 performance 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.

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 pro-actively.

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
	Referral to Treatment waiting times for non-urgent consultant-led treatment														
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												
	Diagnostics														
EB4	Percentage of Service Users waiting 6 weeks or more from referral for a diagnostic test.	1%	0.7%												
	Cancelled Elective Operations (RWT)														
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												
	A&E Waits														

		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%												
EBS5	Trolley waits in A&E not longer than 12 hours (RWT* position).	0	7												
	Cancer Waits - two week waits														
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%												
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%												
	Cancer Waits - one month (31 days) waits														
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%												
EB9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery.	94%	66.7%												
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%												
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%												
	Cancer Waits - two month (62 days) waits														
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%												
EB13	Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from a NHS Cancer Screening Service.	90%	100%												
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%												
	Health Care Acquired Infections														
EAS4	Zero tolerance Meticillin Resistant *Staphylococcus Aureus.*	0	2												
EAS5	Minimise rates of Clostridium difficile.	70	44												
	Mental Health														
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%												
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)												**

		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)												**
EA3	IAPT - People who have entered treatment as a proportion of people with anxiety or depression (local prevalence).	19%	16.7% (Feb data)												**
EAS2	IAPT - Percentage of people who are moving to recovery of those who have completed treatment in the reporting period.	50%	60% (Feb data)												**
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%												

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 13th 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. 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):**

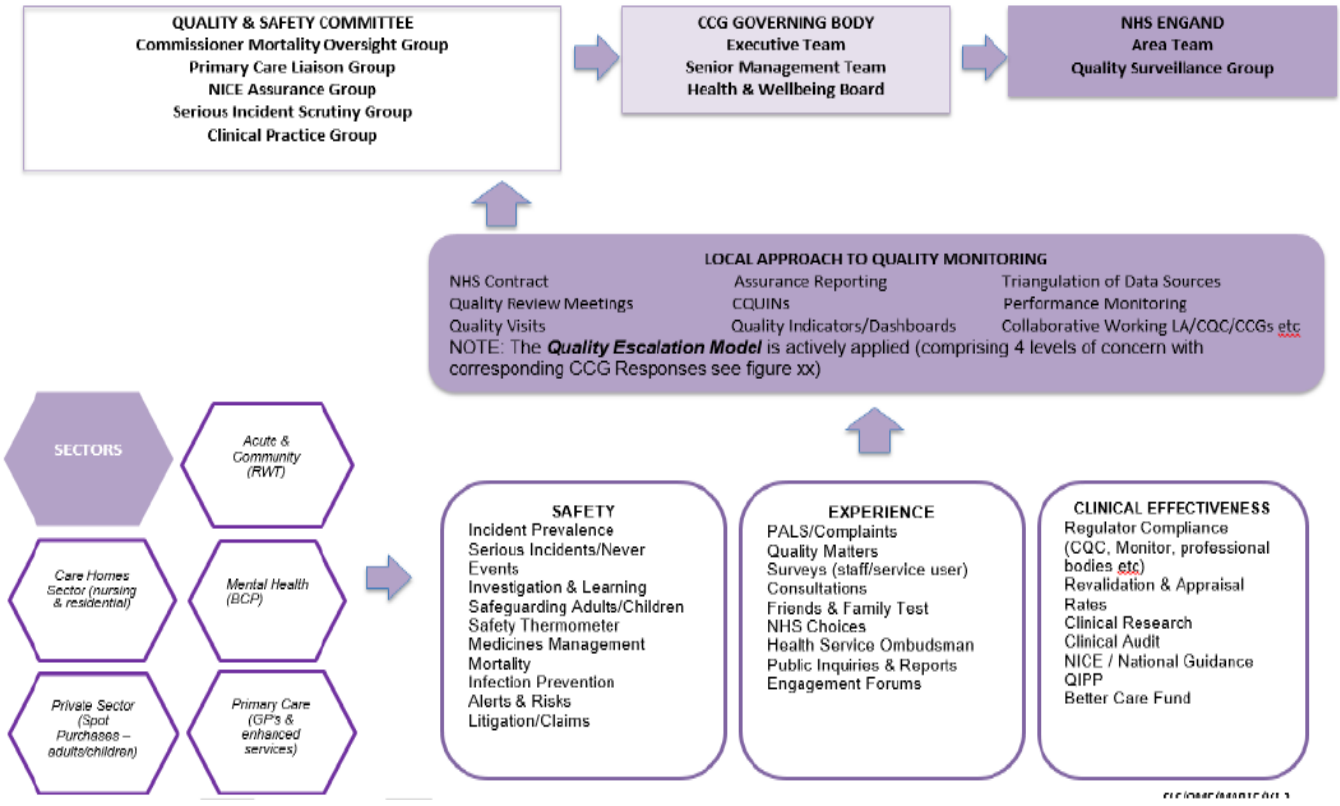
The two year formal SPACE programme has now been completed. The aim of the programme was to train staff and managers in service improvement techniques, with the aim of strengthening the safety culture and reducing adverse events. Embedding this across Wolverhampton is the legacy that will incorporate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

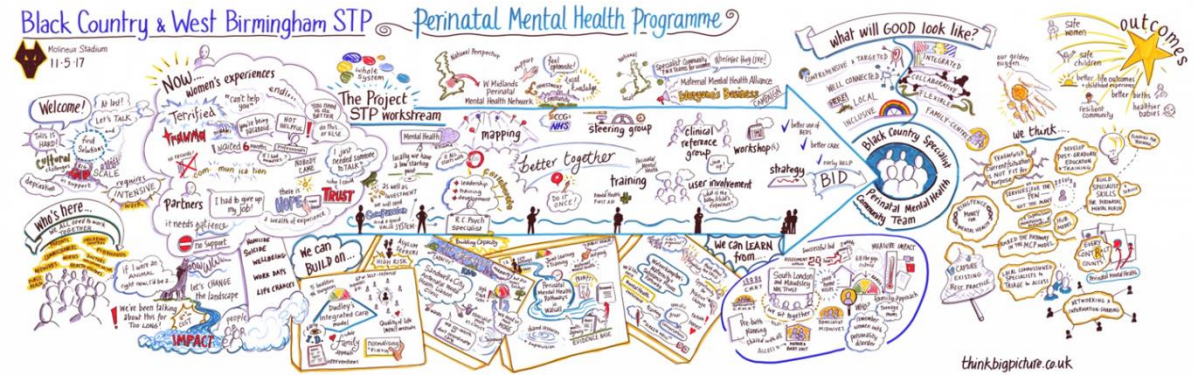
We have worked with our partners across our Mental Health Stakeholder Forum to deliver our programme of mental health awareness on World Mental Health Day, thus supporting our ambition to reduce stigma and increase access to information about mental health services.

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 on 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 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.

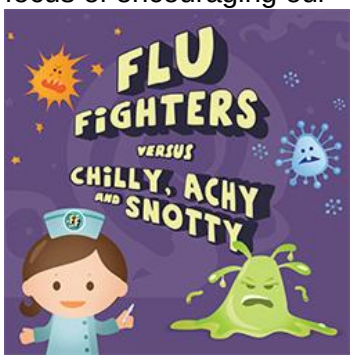
We shared information on how people can help the NHS work effectively and people pledged to do their bit to ensure resources are used responsibly.

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.

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

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

Dr S Ravindran and Majid East Park Medical Centre	Jonesfield Crescent, East Park Wolverhampton WV1 2LW
Dr A Stone and Partners Thornley Street Surgery	40 Thornley Street, Wolverhampton, WV1 1JP
Dr M Sidhu and Partners Lea Road Medical Practice	35 Lea Road, Pennfields Wolverhampton, WV3 0LS
Dr A Sharma Bilston Family Practice	Prouds Lane, Bilston Wolverhampton, WV14 6PW
Dr S Suryani The Surgery	Hill Street, Bradley Wolverhampton WV14 8SE
Dr M Sidhu and Partner West Park Surgery	Park Road West, Tettenhall, Wolverhampton, WV1 4TF
Dr P Venkataramanan and Partners Grove Medical Centre BRANCHES 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	175 Steelhouse Lane Wolverhampton, WV2 2AU
Drs Vij and Vij Whitmore Reans Health Centre BRANCHES Pendeford Health Centre Ednam Road Surgery	Lowe Street, Whitmore Reans Wolverhampton, WV6 0QL
Dr P Wagstaff and Partners Castlecroft Medical Practice	Castlecroft Avenue Wolverhampton WV3 8JN
Dr N Whitehouse Tettenhall Road Medical Practice	199 Tettenhall Road Wolverhampton, WV6 0DD
Drs A Williams and Partners Warstones Health Centre	Pinfold Grove, Warstones Wolverhampton, WV4 4PS
Wolverhampton Doctors On Call Ltd	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 Amarbaj 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
Clinical ~																	
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
Management ~																	
Mr Mike Hastings			✓		✓		✓		✓		x		x		✓		✓
Dr Helen Hibbs			x		✓		✓		✓		✓		✓		✓		✓
Mr Steven Marshall			✓		✓		✓		✓		✓		x		✓		✓
Mr T Gallagher			✓		✓		✓		✓		✓		✓		✓		✓
Mr M Hartland			✓		✓		✓		✓		✓		✓		x		x
Lay Members/ Consultant ~																	
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 Section14R 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;

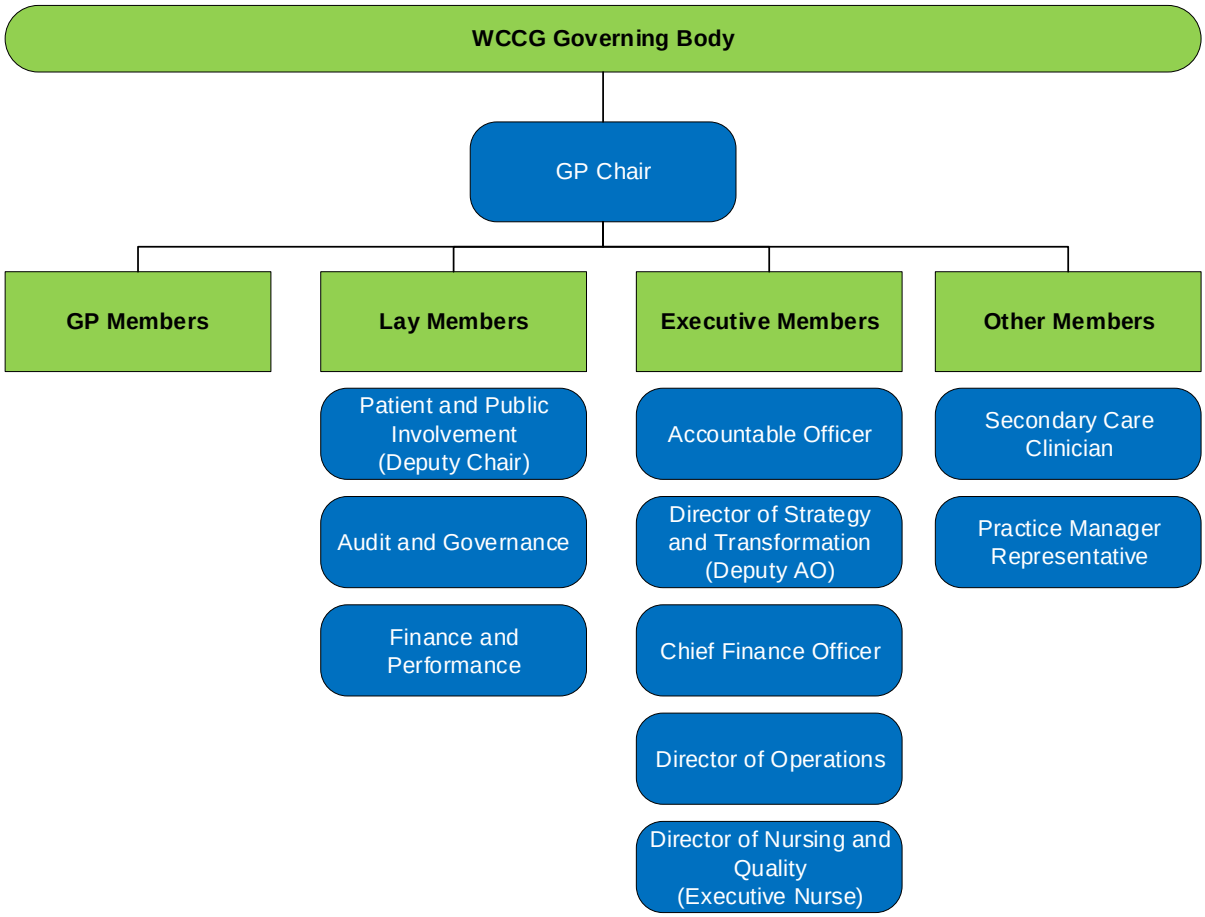
e) the Equality Act 2010."

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[1] 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.

[1] - *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:

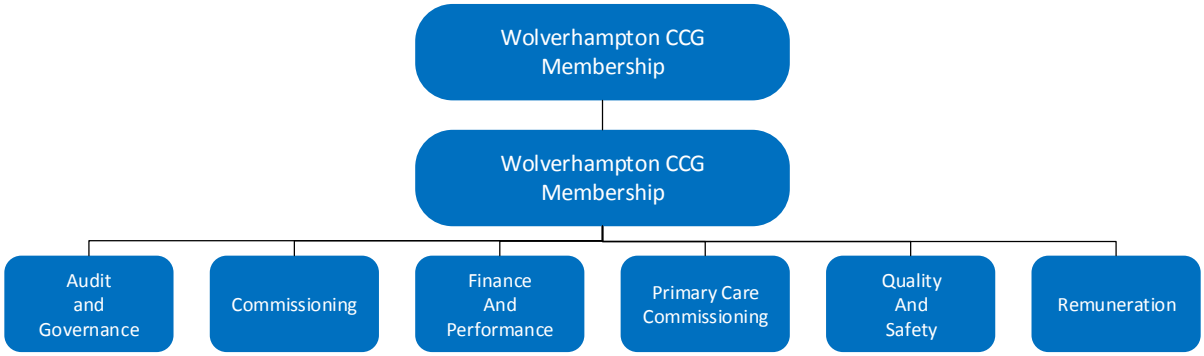
- Audit & Governance
- Commissioning
- Finance & Performance
- Primary Care Commissioning[2]
- Quality & Safety
- Remuneration

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

[2] 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.

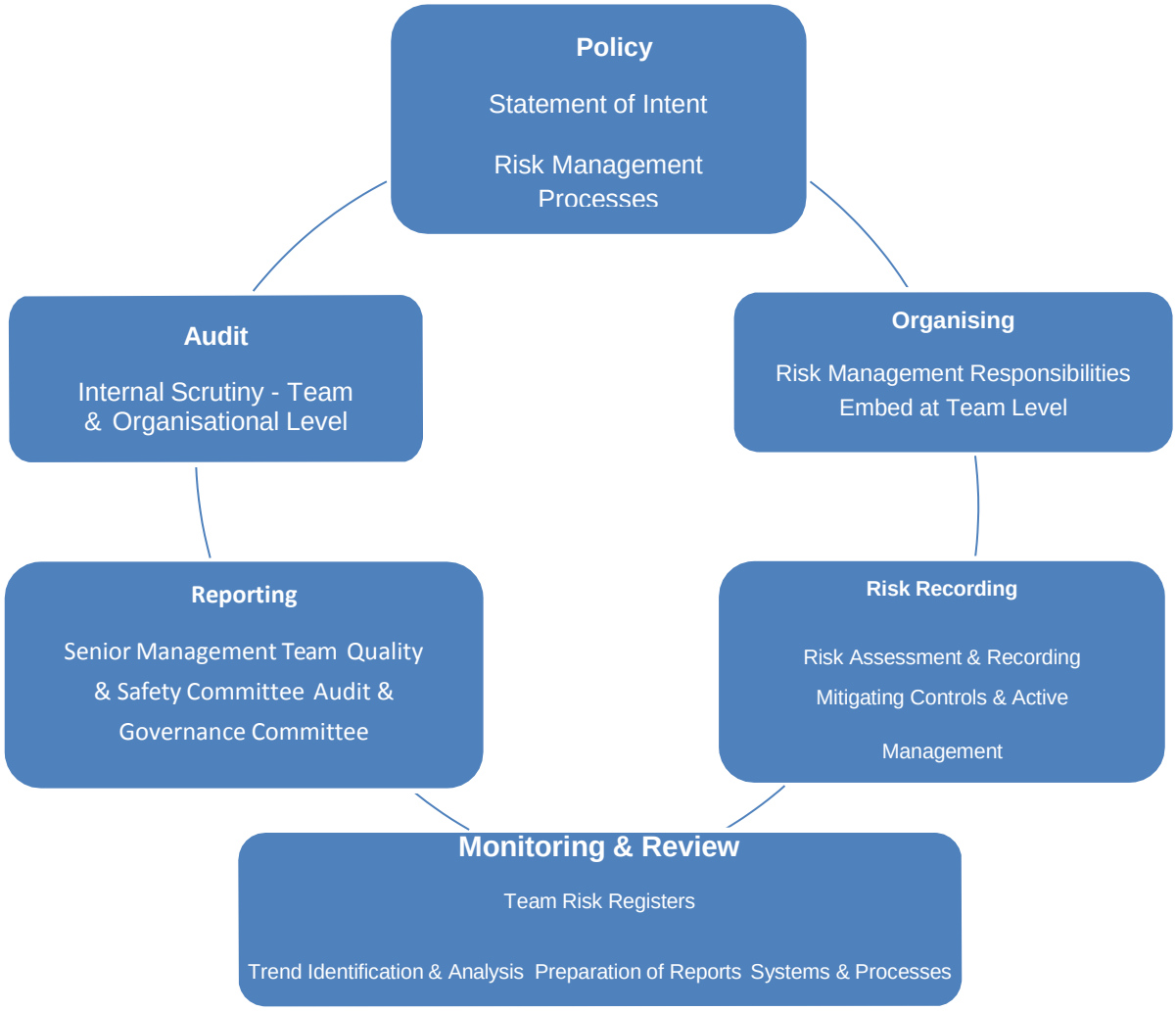
The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

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:

Area of Audit	Level of Assurance Given
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

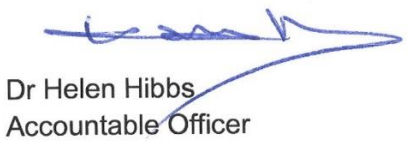
My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn 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
Members				
Peter Price, Independent Committee Member (Chair)	✓	✓	✓	✓
Dr David Bush, Governing Body Member, CCG	✓	✓		✓
Dr Manjit Kainth Governing Body Member, CCG	✓	✓	✓	✓
Jim Oatridge, Independent Committee Member			✓	✓

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	£00
H Hibbs - Accountable Officer	0-2.5	0-2.5	15-20	50-55	371	17	418	0
T Gallagher - Chief Finance Officer *	7.5-10	22.5-25	40-45	130-135	761	252	1055	0
M Hartland - Strategic Finance Officer ** ~	2.5-5	0-2.5	45-50	110-115	680	112	829	0
S Roberts - Chief Nurse & Director of Quality (commenced in post 05/02/18) ~	2.5-5	10-12.5	35-40	115-120	638	145	815	0
S Marshall - Director of Strategy & Transformation # ~	0-2.5	0	15-20	0	197	38	255	0
M Hastings - Director of Operations ~	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 1-4-18.
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.

2018/19						
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	125-130	0	10-15 #	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 31st December 2018 and 12 month rolling sickness is 1.79% up to 31st 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 mail 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
Gross employee benefits expenditure	**3,147**	**144**	**3,291**	**1,849**	**365**	**2,214**	**4,996**	**509**	**5,505**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**3,147**	**144**	**3,291**	**1,849**	**365**	**2,214**	**4,996**	**509**	**5,505**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**3,147**	**144**	**3,291**	**1,849**	**365**	**2,214**	**4,996**	**509**	**5,505**

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
Employee Benefits									
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
Gross employee benefits expenditure	**2,927**	**108**	**3,032**	**1,561**	**456**	**2,017**	**4,484**	**565**	**5,049**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**2,927**	**108**	**3,032**	**1,561**	**456**	**2,017**	**4,484**	**565**	**5,049**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,927**	**108**	**3,032**	**1,561**	**456**	**2,017**	**4,484**	**565**	**5,049**

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
Grand Total	**99**	**36**	**135**

**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
Of which, the number that have existed:	
• 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 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
Of which:	
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.

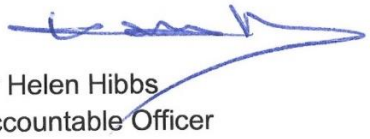
External Auditor's Remuneration

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

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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The Primary Statements:

Notes to the Accounts

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)
Total operating income		**(677)**	**(1,895)**
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
Total operating expenditure		**414,685**	**396,125**
Net Operating Expenditure		**414,008**	**394,230**
Finance income		-	-
Finance expense		-	-
Net expenditure for the year		**414,008**	**394,230**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**414,008**	**394,230**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
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		-	-
Items that may be reclassified to Net Operating Costs			
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
Sub total		**-**	**-**
Comprehensive Expenditure for the year ended 31 March 2019		**414,008**	**394,230**

Statement of Financial Position as at 31 March 2019

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

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19				
Balance at 01 April 2018	(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**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(32,318)**	**0**	**0**	**(32,318)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
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**
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
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
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(414,008)**	**0**	**0**	**(414,008)**
Net funding	408,443	0	0	**408,443**
Balance at 31 March 2019	**(37,883)**	**0**	**0**	**(37,883)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18				
Balance at 01 April 2017	(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**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(20,682)**	**0**	**0**	**(20,682)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
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
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
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
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(394,230)**	**0**	**0**	**(394,230)**
Net funding	382,594	0	0	382,594
Balance at 31 March 2018	**(32,318)**	**0**	**0**	**(32,318)**

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

Statement of Cash Flows for the year ended 31 March 2019

	2018-19 £'000	2017-18 £'000
Cash Flows from Operating Activities		
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)
Net Cash Inflow (Outflow) from Operating Activities	**(408,461)**	(382,541)
Cash Flows from Investing Activities		
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
Net Cash Inflow (Outflow) from Investing Activities	**0**	0
Net Cash Inflow (Outflow) before Financing	**(408,461)**	(382,541)
Cash Flows from Financing Activities		
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
Net Cash Inflow (Outflow) from Financing Activities	**408,443**	382,594
Net Increase (Decrease) in Cash & Cash Equivalents	**(18)**	53
Cash & Cash Equivalents at the Beginning of the Financial Year	**85**	32
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies	0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	**67**	85

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.

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 measure 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 £'000	2017-18 Total £'000
Income from sale of goods and services (contracts)		
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	**-**	-
Total Income from sale of goods and services	**-**	**-**
Other operating income		
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
Total Other operating income	**677**	**1,895**
Total Operating Income	**677**	**1,895**

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
Employee Benefits			
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**
Gross employee benefits expenditure	4,996	509	5,505
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	4,996	509	5,505
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	4,996	509	5,505

4.1.1 Employee benefits 2017-18

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
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**
Gross employee benefits expenditure	4,488	565	5,053
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	4,488	565	5,053
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	4,488	565	5,053

4.1.2 Recoveries in respect of employee benefits

	Permanent Employees £'000	Other £'000	2018-19 Total £'000	2017-18 Total £'000
Employee Benefits - Revenue				
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	**-**	**-**	**-**	**-**
Total recoveries in respect of employee benefits	-	-	-	-

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**
Total	**95.52**	**6.50**	**102.02**	**85.00**	**6.00**	**91.00**
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	4	7

	2018-19 Number	2017-18 Number
Number of persons retired early on ill health grounds	0	0

	£'000	£'000
Total additional Pensions liabilities accrued in the year	0	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. 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
Purchase of goods and services		
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	-	-
Total Purchase of goods and services	**408,659**	**390,700**
Depreciation and impairment charges		
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	-	-
Total Depreciation and impairment charges	**-**	**-**
Provision expense		
Change in discount rate	-	-
Provisions	218	(27)
Total Provision expense	**218**	**(27)**
Other Operating Expenditure		
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
Total Other Operating Expenditure	**303**	**399**
Total operating expenditure	**409,180**	**391,072**

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

Measure of compliance	**2018-19 Number**	**2018-19 £'000**	2017-18 Number	2017-18 £'000
Non-NHS Payables				
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
Percentage of Non-NHS Trade invoices paid within target	**97.9%**	**99.1%**	97.6%	99.0%
NHS Payables				
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
Percentage of NHS Trade Invoices paid within target	**98.9%**	**99.7%**	99.4%	99.8%

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2018-19 £'000**	2017-18 £'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**-**	**-**

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

	2018-19				2017-18			
	Land £'000	**Buildings £'000**	**Other £'000**	**Total £'000**	**Land £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payments recognised as an expense								
Minimum lease payments	-	712	8	**720**	-	674	6	**680**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**712**	**8**	**720**	**-**	**674**	**6**	**680**

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

	2018-19				2017-18			
	Land £'000	**Buildings £'000**	**Other £'000**	**Total £'000**	**Land £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payable:								
No later than one year	-	26	-	**26**	-	40	4	**44**
Between one and five years	-	-	-	**-**	-	-	-	**-**
After five years	-	-	-	**-**	-	-	-	**-**
Total	**-**	**26**	**-**	**26**	**-**	**40**	**4**	**44**

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

	Current 2018-19 £'000	Non-current 2018-19 £'000	Current 2017-18 £'000	Non-current 2017-18 £'000
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	-
Total Trade & other receivables	**4,785**	**-**	**3,582**	**-**
Total current and non current	**4,785**		**3,582**	
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

	2018-19 DHSC Group Bodies £'000	2018-19 Non DHSC Group Bodies £'000	2017-18 DHSC Group Bodies £'000	2017-18 Non DHSC Group Bodies £'000
By up to three months	115	316	805	53
By three to six months	314	-	-	-
By more than six months	33	-	5	-
Total	**462**	**316**	**810**	**53**

£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

	Cash and cash equivalents £000s	Trade and other receivables - NHSE bodies £000s	Trade and other receivables - other DHSC group bodies £000s	Trade and other receivables - external £000s	Other financial assets £000s	Total £000s
Classification under IAS 39 as at 31st March 2018						
Financial Assets held at FVTPL	-	-	-	-	-	**-**
Financial Assets held at Amortised cost	85	2,350	-	189	4	**2,628**
Financial assets held at FVOCI	-	-	-	-	-	**-**
Total at 31st March 2018	**85**	**2,350**	**-**	**189**	**4**	**2,628**
Classification under IFRS 9 as at 1st April 2018						
Financial Assts 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	-	-	-	-	-	**-**
Total at 1st April 2018	85	2,350	-	189	4	**2,628**
Changes due to change in measurement attribute	-	-	-	-	-	**-**
Other changes	-	-	-	-	-	**-**
Change in carrying amount	-	-	-	-	-	**-**

17.4 Movement in loss allowances due to application of IFRS 9

	Trade and other receivables - NHSE bodies £000s	Trade and other receivables - other DHSC group bodies £000s	Trade and other receivables - external £000s	Other financial assets £000s	Total £000s
Impairment and provisions allowances under IAS 39 as at 31st March 2018					
Financial Assets held at Amortised cost (ie the 1718 Closing Provision)	-	-	(7)	-	**(7)**
Financial assets held at FVOCI	-	-	-	-	**-**
Total at 31st March 2018	**-**	**-**	**(7)**	**-**	**(7)**
Loss allowance under IFRS 9 as at 1st April 2018					
Financial Assets measured at amortised cost	-	-	(7)	-	**(7)**
Financial Assets measured at FVOCI	-	-	-	-	**-**
Total at 1st April 2018	**-**	**-**	**(7)**	**-**	**(7)**
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

	2018-19 £'000	2017-18 £'000
Balance at 01 April 2018	85	32
Net change in year	(18)	53
Balance at 31 March 2019	**67**	**85**
Made up of:		
Cash with the Government Banking Service	67	85
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**67**	**85**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2019	**67**	**85**

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).

23 Trade and other payables	Current 2018-19 £'000	Non-current 2018-19 £'000	Current 2017-18 £'000	Non-current 2017-18 £'000
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	-
Total Trade & Other Payables	**42,337**	**-**	**35,758**	**-**
Total current and non-current	**42,337**		**35,758**	

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
Classification under IAS 39 as at 31st March 2018						
Financial Assets held at FVTPL	-	-	-	-	-	**-**
Financial Assets held at Amortised cost	7,295	-	28,332	-	-	**35,627**
Total at 31st March 2018	**7,295**	**-**	**28,332**	**-**	**-**	**35,627**
Classification under IFRS 9 as at 1st April 2018						
Financial Liabilities designated to FVTPL	-	-	-	-	-	**-**
Financial Liabilities mandated to FVTPL	-	-	-	-	-	**-**
Financial Liabilities measured at amortised cost	7,295	-	28,332	-	-	**35,627**
Financial Assets measured at FVOCI	-	-	-	-	-	**-**
Total at 1st April 2018	7,295	-	28,332	-	-	**35,627**
Changes due to change in measurement attribute	-	-	-	-	-	**-**
Other changes	-	-	-	-	-	**-**
Change in carrying amount	-	-	-	-	-	**-**

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

	Current 2018-19 £'000	**Non-current 2018-19 £'000**	Current 2017-18 £'000	Non-current 2017-18 £'000
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	-
Total	**398**	**-**	**227**	**-**
Total current and non-current	**398**		**227**	

	Continuing Care £'000	**Other £'000**	**Total £'000**
Balance at 01 April 2018	**37**	**190**	**227**
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	-	-	**-**
Balance at 31 March 2019	**22**	**376**	**397**
Expected timing of cash flows:			
Within one year	22	376	**397**
Between one and five years	-	-	**-**
After five years	-	-	**-**
Balance at 31 March 2019	**22**	**376**	**397**

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 tears 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

	Financial Assets measured at amortised cost 2018-19 £'000	Equity Instruments designated at FVOCI 2018-19 £'000	Total 2018-19 £'000
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
Total at 31 March 2019	**3,470**	**-**	**3,470**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2018-19 £'000	Other 2018-19 £'000	Total 2018-19 £'000
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	-	-	-
Total at 31 March 2019	**42,182**	**-**	**42,182**

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 1st 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 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.

	2018-19 £'000	2017-18 £'000
Pool Expenditure:		
Community	28,929	30,561
Dementia	2,727	2,717
Mental Health	7,493	7,062
Total Pool Expenditure	**39,149**	**40,340**
Funding:		
Wolverhampton CCG Baseline	36,541	37,549
Wolverhampton CCG Share of Overspend	2,608	2,791
	39,149	**40,340**

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:

		2018-19				2017-18			
		Payments to Related Partv £'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 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

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	**Practice**	**2018-19 £000**	2017-18 £000
Dr D Bush, GP Member	Penn Surgery	693	578
Dr R Rajcholan, GP Member	Ashmore Park Health Centre	473	432
Dr M Kainth, GP Member	Primrose Lane Clinic	323	354
Dr S Reehana, Clinical Chair Dr M Asghar, GP Member	Grove Medical Centre	1,977	1,442
Dr J Parkes, GP Member	Alfred Squire Medical Practice	1,241	1,225
Dr R Gulati, GP Member	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	**2018-19**	2017-18	2017-18
	Target	**Performance**	Target	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	-	-	-	-
Total	**1**	**-**	**2**	**-**

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	-	-	-	-
Total	**-**	**-**	**1**	**110**

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. 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[1], 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