NHS
Wolverhampton
Clinical Commissioning Group

An Extraordinary meeting of the Wolverhampton Clinical Commissioning Group Governing Body

will take place on Tuesday 22nd May 2018 commencing at 1.00 pm

at Wolverhampton Science Park, Stephenson Room

A G E N D A

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		2	Declarations of Interest		
		3	Minutes of the meeting of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on 8 May 2018		1 - 10
		4	Matters arising from the minutes		
			Items for Decision		
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			Items for Assurance		
		6	Committee Annual Reports	Mr P McKenzie	11 - 60
			Items for Information		
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		8	Any Other Business		
		9	Members of the Public/Press to address any questions to the Governing Body		
			Date and time of next meeting ~ Tuesday 10 July 2018 – Governing Body Board Meeting		

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NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CLINICAL COMMISSIONING GROUP GOVERNING BODY

Minutes of the Governing Body Meeting held on Tuesday 8 May 2018
Commencing at 1.00 pm at Wolverhampton Science Park, Stephenson Room

Attendees ~

Dr S Reehana	Chair

Clinical

Dr D Bush	Board Member
Dr R Gulati	Board Member
Dr M Kainth	Board Member
Dr J Parkes	Board Member

Management

Mr T Gallagher	Chief Finance Officer – Walsall/Wolverhampton
Mr M Hastings	Director of Operations
Mr S Marshall	Director of Strategy and Transformation
Ms S Roberts	Chief Nurse Director of Quality

Lay Members/Consultant

Mr A Chandock	Secondary Care Consultant
Mr J Oatridge	Lay Member
Mr P Price	Lay Member
Ms H Ryan	Lay Member
Mr L Trigg	Lay Member

In Attendance

Ms K Garbutt	Administrative Officer
Mr M Hartland	Chief Finance Officer – Dudley CCG (Strategic Financial Adviser)
Ms Y Higgins	Deputy Chief Nurse (observer)
Mr P McKenzie	Corporate Operations Manager
Mr H Patel	Head of Medicines Optimisation
Ms S Sandhar	Deputy Head of Medicines Optimisation (observer)
Ms S Southall	Head of Primary Care (part)

Apologies for absence

Apologies were received from Mr D Watts, Ms S Gill and Dr R Rajcholan.

Declarations of Interest

WCCG.2108 There were no declarations of interest declared.

RESOLVED: That the above is noted.

Minutes of the meeting of the Wolverhampton Clinical Commissioning Group Governing

WCCG.2109 RESOLVED:

That the minutes of the Wolverhampton Clinical Commissioning Group Governing Body meeting held on the 10 April 2018 be approved as a correct record.

Matters arising from the Minutes

WCCG.2110 There were no matters arising.

RESOLVED: That the above is noted.

Committee Action Points

WCCG.2111 RESOLVED: That the progress report against actions requested at previous Board meetings be noted.

Chief Officer Report

WCCG.2112 Dr Hibbs presented the report. She highlighted the End of Year Assurance Meeting for Wolverhampton Clinical Commissioning Group (WCCG) with NHS England was held on the 18 April 2018. This was a useful opportunity for the CCG to showcase its work and we received positive feedback on the day.

She mentioned that the Mental Health Transforming Care Together (TCT) programme is no longer going ahead. However the two Mental Health Trusts in the Black Country are continuing to work closely together to ensure that the positive benefits that have accrued as part of the programme are not lost.

Mr M Hartland arrived

A refresh of the leadership of the Black Country Sustainability and Transformation Plan (STP) is currently taking place. Dr Hibbs confirmed she has agreed to provide support in the form of Senior Responsibility Officer. In addition we are currently in the process of appointing an independent chair and refreshing the programme delivery arrangements.

In addition to the overarching Integrated Care System work, we continue to work in Wolverhampton to develop an alliance arrangement with Primary Care Acute and community Services, Mental Health and the Local Authority. Current discussions are focussing on the clinical model and the evolving governance arrangements.

RESOLVED: That the above is noted

Items which should not routinely be prescribed in Primary Care (consultation 1)

WCCG.2113 Mr H Patel gave an overview of the report. He stated that the Governing Body requested legal opinion to be obtained to determine whether any local consultation was required to compliment the national consultation. Legal advice recommends the Clinical Commissioning Group (CCG) include a process of engagement and involvement to support the implementation.

With the support of the Communication and Engagement Team, we propose a series of engagement and involvement events to advise the local population of the recommendations and through a patient involvement approach.

NHS England has published guidance for all prescribers and CCGs to remove 18 ineffective, unsafe and low clinical value treatments as detailed on page 4 of the report.

RESOLVED:

(a) That the Governing Body supported the principle outcome of the NHS England consultation on items which should not routinely be prescribed in Primary Care.

(b) That the Governing supported the decision to include a process of engagement and involvement, followed by a series of communications aimed at supporting patients and practices to implement the outcome, within a defined timeframe for implementation.

Conditions for which over the counter items should not routinely be prescribed in Primary Care (consultation 2)

WCCG.2114 Mr Patel presented the report. He pointed out that legal advice has been sought, which recommends the CCG undertakes a process of engagement to support the implementation of NHS England outcome. Mr Patel pointed out the importance of the engagement and hopefully the Care Navigators within practices will be able to help. Dr Hibbs added that we could not have a blanket ban this is about education and how we use this piece of work. Ms S Roberts stated that engagement and education is so critical and the importance for this to be communicated out to practices.

RESOLVED:

(a) That the Governing Body supports the outcome of the NHS England consultation on conditions for which over the counter items should not routinely be prescribed in Primary Care.
(b) That the Governing Body supports that a fully impact analysis is carried out prior to implementation taking into account GP members views as detailed within appendix 1 of the report.
(c) That the Governing Body supports a process of engagement and involvement events, followed by a series of communications aimed at supporting patients and practices to implement the outcome.

Report of Responses following the Public Consultation on Gluten Free Prescribing (consultation 3)

WCCG.2115 Mr Patel presented the report. He pointed out the NHS England consultation outcome and the preferred option to only allow the prescribing of certain Gluten Free foods, bread and flour, in Primary Care. This is likely to result in retaining a smaller range of bread and mixes, as the preferred product types following the consultation.

The CCG should await the impact of the regulatory changes before proceeding with a full patient consultation exercise on further restriction of Gluten Free prescribing

RESOLVED:

(a) That the Governing Body supports the principle outcome of the NHS England consultation on Gluten Free Prescribing in Primary Care.
(b) That the CCG await further national review, expected in December 2018, with regards restriction of additional products.

Ms Sarah Southall arrived
Mr Hemant Patel and MsSukvinder Sandhar left

Governing Body Assurance Framework

WCCG.2116 Mr P McKenzie referred to the report which outlines the latest position of the CCG's Risk Management arrangements, including the latest updated Governing Body Assurance Framework (GBAF) and Corporate Risk Register.

Mr McKenzie pointed out the key changes to risks since the Governing Body considered the register in February on page 4 of the report. As part of their review of risks the Finance and Performance Committee have discussed the most effective way to articulate and manage risks associated with financial performance. He pointed out the Committee's suggestion is to maintain the individual risk on the risk register as it is less likely to change and fluctuate on a regular basis.

He referred to the Transforming Care Partnership. An additional corporate risk associated with the Black Country Transforming Care for Learning Disabilities programme has been identified, which is supported by relevant committee risks at the Finance and Performance and Quality and Safety Committees. The Governing Body is asked to consider which committee should own and manage this risk. Mr McKenzie suggested this should sit with Finance and Performance Committee and Mr Gallagher supported this.

RESOLVED: That the above is noted

Mr Chandock left

Primary Care Strategy Delivery update

WCCG.2117 Ms Southall presented the report. She highlighted progress made in the last three months pointing out the back office functions review is now completed. Groups have identified which areas they wish to progress; these include subscriptions and other non-clinical support services.

The Home Visiting service pilot project business case and service specification have been approved at Primary Care Commissioning Committee.

Dr Asghar arrived

The QOF+ Scheme 2018/19 has been finalised and shared for consideration with a range of forums. Feedback captured and final changes made. Approval is anticipated in May, implementation will take place thereafter. This was discussed at the Members Meetings and was well received.

The Mental Health Primary Care Steering Group is also scoping a potential service development for advice and guidance with Black Country Partnership Foundation Trust.

Ms Southall pointed out the General Practice Forward View Programme and Self-Assessment 2018/19 in appendix 1 on the report. Dr S Reehana commended the work carried out. Mr Oatridge added he is very pleased to see the programme of work. The progress makes it clear what you hope to achieve in the future.

RESOLVED: That the above is noted

Sarah Southall left

Commissioning Committee

WCCG.2118 Dr M Kainth presented the report. He highlighted the Night Repositioning Service Pilot. The Committee was presented with a business case for the commissioning of a six month pilot of a service to provide night time interventions for patients living at home affected by pressure injuries. The Committee approved the business case and requested that the pilot should be for a period of 12 month to allow a more robust evaluation process.

Dr Kainth pointed out the Contracting update.

RESOLVED: That the above is noted.

Quality and Safety Committee

WCCG.2119 Ms Roberts presented the report. She highlighted the key issues within the report pointing out Vocare, the Urgent Care Provider, are showing improvement and their performance is continuing to be monitored. Home visiting and call back performance remains challenging.

She stated that maternity capping still continues. There has been an increase in the number of Never Events. Ms Roberts and Dr Reehana met with the Trust Board to discuss these. They were given a level of assurance that these are being addressed.

Cancer performance for the Trust remains an area requiring further assurance. In particular 62 and 104 day cancer performance requires further assurance to ensure any potential or actual impact of harm for patients is understood and mitigated.

RESOLVED: That the above is noted.

Finance and Performance Committee

WCCG.2120 Mr T Gallagher gave an overview of the report. He pointed out the key financial performance indicators on page 3 of the report. The CCG has been required to increase its control total (surplus) from £9.130m to £11.26m as a result of NHS England guidance.

No additional Quality, Innovation, Productivity and Prevention (QIPP) has been identified in month 12. The CCG is reporting achieving its QIPP target as the shortfall is being covered by reserves and other under spends. Page 5 of the report shows the main areas of movement with Acute services at the beginning of the table.

Mr Gallagher reported that the Auditors are happy with the final accounts at this stage and commended the Finance Department.

Dr Hibbs thanked the Finance team and other teams for their work during the year and commented that this is a very strong financial position to end the year on.

RESOLVED: That the above is noted

Audit and Governance Committee

WCCG.2121 Mr P Price gave an overview of the report. He pointed out the Final Review of Effectiveness and whether other Committees could also carry this review out. Mr Hartland and Dr Hibbs supported this being adopted in the other committees

RESOLVED: That the above is noted.

Communication and Engagement update

WCCG.2122 Ms S McKie presented the report. She referred to the extended opening for Pharmacy and GP surgeries over the May Bank Holiday.

She stated that this year's annual Report has been compiled and submitted the first draft to NHS England. Currently the required amendments are being made ready for the next submission to NHS England.

RESOLVED: That the above is noted.

Minutes of the Quality and Safety Committee

WCCG.2123 RESOLVED: That the minutes are noted.

Minutes of the Finance and Performance Committee

WCCG.2124 RESOLVED: That the minutes are noted.

Minutes of the Commissioning Committee

WCCG.2125 RESOLVED: That the minutes are noted.

Minutes of the Audit and Governance Committee

WCCG.2126 RESOLVED: That the minutes are noted.

Any Other Business

WCCG.2127 RESOLVED: That the above is noted.

Members of the Public/Press to address any questions to the Governing Board

WCCG.2128 A member of the public raised concerns regarding a referral she had received from her GP last year to the crisis service and would like some advice and assistance. Dr Hibbs stated she would take this up outside the meeting with her.

RESOLVED: That the above is noted.

Date of Next Meeting

WCCG.2129 The Board noted that the next meeting was due to be held on **Tuesday 22 May 2018** to commence **at 1.00 pm** and be held at Wolverhampton Science Park, Stephenson Room.

The meeting closed at 2.15 pm

Chair……..

Date ……

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NHS
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Clinical Commissioning Group

WOLVERHAMPTON CCG

GOVERNING BODY
22 MAY 2018

Agenda item 6

TITLE OF REPORT:	Committee Annual Reports
AUTHOR(s) OF REPORT:	Peter McKenzie, Corporate Operations Manager
MANAGEMENT LEAD:	Peter McKenzie, Corporate Operations Manager
PURPOSE OF REPORT:	To introduce the annual reports of the Governing Body Committees, which have been submitted to demonstrate that they have met their terms of reference.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	• Each of the Governing Body Committees is required to assess how effectively it has met its terms of reference. • The committees discharge this duty by producing an Annual Report detailing their work to demonstrate how they have discharged their terms of reference. • The reports are submitted to the Governing Body to provide assurance that the Committees have achieved the requirements of their terms of reference.
RECOMMENDATION:	That the Governing Body receive and note the Committee Annual Reports.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
3. System effectiveness delivered within our financial envelope	<u>Continue to meet our Statutory Duties and responsibilities</u> The Committee Annual Reports include details of how the Committees have discharged any statutory duties that have been delegated to them. The Committee Annual Reports have also been used to support the Accountable Officer in the preparation of the Annual Governance Statement.

1. BACKGROUND AND CURRENT SITUATION

1.1. The Terms of Reference for the committees of the Governing Body set out in the Constitution set out what their areas of responsibility are. The terms of reference also include a requirement to assess how effectively they have met these terms of reference and to demonstrate to the Governing Body how they have achieved this.

1.2. The committees discharge this requirement by producing annual reports detailing their work throughout the year. This builds on the regular reporting from each committee to the Governing Body to provide an overall assessment for the Governing Body to assure how effectively the committees are operating.

2. ANNUAL REPORTS

2.1. As with previous years, the committees have chosen to reflect on their work based on broad themes drawn from their terms of reference rather than giving a chronological account of meetings throughout the year. This allows the Governing Body to have an overview of their work and has allowed the committees to assess their effectiveness across the full scope of their areas of responsibility in their terms of reference.

2.2. The Annual Reports are designed to complement the regular reports from the committees to the Governing Body, which have given detailed descriptions of the work undertaken on a monthly basis. The Annual Reports have been considered at Committee meetings throughout April and May.

2.3. As well as providing the Governing Body with assurance on the work of the Committees, the content of the annual reports has been used to support the Chief Officer in preparing the Annual Governance Statement, which forms part of the Annual Report. This includes brief details of work undertaken by each of the committees that relate to the CCG's overall governance framework.

2.4. Each of the committee's reports are attached for comment by the Governing Body. And will be published on the CCG's website.

3. CLINICAL VIEW

3.1. The clinical committee chairs have been involved in the production of the annual reports.

4. PATIENT AND PUBLIC VIEW

4.1. Not applicable.

5. KEY RISKS AND MITIGATIONS

5.1. There are no risks associated with this report. The reports include details of the work of the committees to manage risks associated with their work.

6. IMPACT ASSESSMENT

Financial and Resource Implications

6.1. There are no financial implications arising from this report.

Quality and Safety Implications

6.2. There are no Quality and Safety implications arising from this report.

Equality Implications

6.3. There are no Equality implications arising from this report.

Legal and Policy Implications

6.4. The annual reports have been produced in line with the requirement within the committee terms of reference. They have been used in the preparation of the Governance Statement as part of the assessment of the CCG's governance framework. No significant issues have been identified.

Name	Peter McKenzie
Job Title	Corporate Operations Manager
Date:	May 2018

NHS
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REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	N/a	
Public/ Patient View	N/a	
Finance Implications discussed with Finance Team	N/a	
Quality Implications discussed with Quality and Risk Team	N/a	
Equality Implications discussed with CSU Equality and Inclusion Service	N/a	
Information Governance implications discussed with IG Support Officer	N/a	
Legal/ Policy implications discussed with Corporate Operations Manager	N/a	
Other Implications (Medicines management, estates, HR, IM&T etc.)	N/a	
Any relevant data requirements discussed with CSU Business Intelligence	N/a	
Signed off by Report Owner (Must be completed)	**Peter McKenzie**	**11/05/2018**

NHS
Wolverhampton
Clinical Commissioning Group

ANNUAL REPORT

Audit and Governance Committee
2017/2018

DOCUMENT STATUS:	First Draft discussed at Committee
DATE ISSUED:	May 2018
DATE TO BE REVIEWED:	

AMENDMENT HISTORY

VERSION	DATE	AMENDMENT HISTORY
0.1	17.04.2018	First draft
0.2	22.05.2018	Final Draft for Committee and Governing Body

REVIEWERS

This document has been reviewed by:

NAME	TITLE/RESPONSIBILITY	DATE	VERSION

APPROVALS

This document has been approved by:

GROUP/COMMITTEE	DATE	VERSION
Audit and Governance Committee	April 2018	0.1
	May 2018	0.2

DOCUMENT STATUS

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RELATED DOCUMENTS

These documents will provide additional information:

REF NUMBER	DOCUMENT REFERENCE NUMBER	TITLE	VERSION

Contents

1. Introduction

1.1 This report provides an overview of the work of the CCG's Audit and Governance Committee during the 2017/18 financial year. This Committee is the CCG's statutory Audit Committee, appointed in line with the Health and Social Care Act 2012 and its primary purpose, as defined in its terms of reference, 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 will deliver this remit in the context of the group's priorities, as they emerge and develop, and the risks associated with achieving them..."

1.2 In order to achieve this core purpose, the committee's terms of reference also set out detailed descriptions of specific duties and responsibilities required of it, which are undertaken as the committee meets throughout the year. These terms of reference are incorporated into the Clinical Commissioning Group's Constitution and published on the Group's website.

1.3 This report includes an assessment of how effective the committee has been in achieving its core purpose through meeting the duties and responsibilities in the terms of reference during the year. The evidence contained in this report will be shared with the CCG's Governing Body and also will be used to support the development of the organisations' Annual Governance Statement.

1.4 The committee had four scheduled meetings during the financial year:

- 18 April 2017
- 18 July 2017
- 17 November 2017
- 20 February 2018

As part of the process of signing off the CCG's Annual Report, Financial Statements and reports from the External Auditors the committee also held an additional meeting on 23 May 2017. Details of the attendance at all of these meetings are enclosed at Appendix 1 for information.

1.5 The committee, in line with its constitutional terms of reference, is chaired by the CCG's Lay Member for Audit and Governance and is made up of other Lay Members, including the Lay Member for Finance and Performance and an independent member. During the year, as result of broader changes in the Governing Body, Peter Price has returned to the committee to act as chair, initially on an interim basis and now on a permanent basis. Peter previously served on the committee prior to his appointment as lay member for Finance and Performance and brings both a wealth of experience of the CCG's work and continuity of leadership for the committee. Jim Oatridge, the previous Chair has remained part of the committee following his work as interim chair of the CCG's Governing Body.

1.6 All of the members of the committee have significant experience of financial, audit and governance and risk management matters. The committee considers that its independent make up is vital to ensuring that it discharging its duties in an appropriate way. The members aim to act as a 'critical friend' to the CCG's management team, providing challenge where required to ensure that robust systems of control are maintained.

2. Discharge of Duties during 2017/2018

2.1 As highlighted above, the Audit and Governance Committee has a key role in the CCG's Governance arrangements as its statutory Governing Body audit committee. As part of its role, it is charged with a number of specific duties by the Governing Body. These are listed in full in Appendix 2, but as part of its on-going review of effectiveness, the committee has chosen to group these duties into the following themes:-

- Internal Audit
- External Audit
- Governance
- Assurance/ Risk Management and Internal Control
- Accounting Matters

2.2 Details are set out below of the work undertaken by the committee during the year that give a picture of how these duties have been met. At its meeting in February, the Committee confirmed that this approach to reporting on its work and activity remained appropriate and also agreed to undertake a review of its broader effectiveness in line with national best practice.

Internal Audit

2.3 The Committee has maintained an oversight of the work of the CCG's Internal Audit provision by PricewaterhouseCoopers (PwC) throughout the year. Reports were provided to each scheduled meeting on progress with the Internal Audit Plan, which was agreed by the committee at the beginning of the year. The committee played a key role in ensuring that the finally developed plan was appropriately risk based by seeking assurance that issues such as integrated budgets with the local authority, IT security and QIPP delivery were fully taken into account in its development.

2.4 The Committee undertook a mid-year review of the Internal Audit plan to ensure that it remained focussed on CCG priority areas. This followed work within the CCG to respond to the previous years' internal audit review of risk management arrangements, including a refresh of the Governing Body Assurance Framework and Risk Register to ensure the plan took into account issues raised through this process. As a result, the updated plan included a follow up to the review of risk management arrangements, further details of which are discussed elsewhere in this report.

2.5 As part of the progress reports, the committee receives copies of completed internal audit reports and the committee received a number of reports from the 2016/17 Financial year at the May meeting. Other reports have been brought to the Committee's attention throughout the year. At the February meeting, the committee were also updated on plans to develop the Internal Audit plan for the upcoming 2018/19 financial year.

2.6 Part of the committee's role overseeing the work of the internal audit function is signing off both the internal audit annual report and Head of Internal Audit Opinion. These form a key part of the CCG's broader annual accounting and reporting processes and, the committee considered drafts of both at the April meeting before signing off the final versions at the May meeting. The Committee also received the Internal Audit Charter at its July meeting and subsequently arranged for this to be shared with the wider Governing Body later in the year.

External Audit

2.7 As highlighted in last year's committee report, the CCG have appointed new external auditors, Grant Thornton who have commenced work during the 2017/18 financial year. They provided an introductory report at the November committee meeting before bringing an outline External audit plan to the February meeting. The plan outlined areas to be considered in the external audit, recognising the context the CCG operated in. This reflected developments such as closer working with other NHS organisations through the Sustainability and Transformation Partnership (STP) and new models of primary care delivery as well as the CCG's track record of delivery and NHS England assessment as outstanding.

2.8 Details of the outcome of the work of the CCG's previous external Auditors, Ernst Young, were considered as part of the May meeting. Most significantly, this included the report to those charged with Governance which outlined key findings from the external audit, including the delivery of financial targets and the work to address concerns about risk management, which were found to have been effectively described in the annual reporting. The External Auditors subsequently issued an unqualified opinion on the CCG's financial statements for 2016/17.

Governance

2.9 The committee has maintained a broad overview of the CCG's governance arrangements during the year, in particular maintaining its focus on the CCG's arrangements for managing conflicts of interest. Further guidance from NHS England was considered by the Committee in July, and amendments to the CCG's policy for Declaring and Managing Interest were agreed as a result. The Committee noted that the CCG's policy already reflected many of the changes outlined through the updated guidance from NHS England. The committee also agreed that, in the interests of transparency, declarations of interest from all CCG staff would continue to be published on the CCG's website.

2.10 Throughout the year, the committee has recognised that the CCG's governance arrangements will need to continue to adapt to the local response to the national policy direction towards greater collaboration in the NHS. In the Black Country, this has included the establishment of a Joint Commissioning Committee across the four CCGs that make up the Black Country STP. Whilst the agenda and remit of this committee is still developing, the committee has worked with its equivalent committees in the other CCGs to develop a 'Governance Forum' to discuss approaches to audit work on areas commissioned jointly across the CCGs and how the CCGs will ensure this works effectively. Terms of reference for this group have been agreed and the outcomes of the groups meetings were discussed at the November and February meetings. This will continue to be a standing agenda to support this agenda going forward.

2.11 The Committee also continued its on-going review of the CCG's arrangements for Whistleblowing at its July meeting. Whilst noting that there had not been any disclosures under the whistleblowing policy, the committee made a number of suggestions for refining the policy that were taken into account when the policy was reviewed by the CCG's Remuneration committee at the end of 2017.

2.12 Following a request from the Chair, the committee has received an update on the CCG's preparation for the implementation of the EU General Data Protection

Regulation (GDPR). This included a brief update at the November meeting followed by a full report in February 2018 that outlined the steps taken and the action plan in place to ensure the CCG is compliant with new legislation when it is implemented in May 2018. The committee was assured that a proportionate and effective action plan was in place and that it was being monitored by the Quality and Safety Committee in line with that Committee's terms of reference.

2.13 Finally, as part of assessing its effectiveness, as well as receiving earlier drafts of the annual committee report, the committee has drafted amendments to its terms of reference to take into account its expanded role in risk management. The committee have also been kept updated on the development of the CCG's Annual Governance Statement, including considering an initial draft of the statement in February 2018.

Assurance/ Risk Management and Internal Control

2.14 As highlighted in last year's report, the committee has maintained an overview of the CCG's response to an Internal Audit review of Risk Management that contained a number of significant findings. An action plan was developed, and the committee has been kept updated with progress through the year at each of its scheduled meetings. The Committee noted at its July meeting that a number of actions in the plan had not been completed and have received further assurance at the November and February meetings that significant improvements in line with the action plan had taken place.

2.15 The committee have been advised that Executive responsibility for Risk Management has been transferred to the Director of Operations, with the Corporate Operations Manager taking on day to day responsibility for developing the risk management strategy and supporting teams across the CCG in identifying and reporting risks. In November, the Committee were updated on a revised approach to populating the Governing Body Assurance Framework (GBAF) which had been re-profiled around the CCG's strategy priorities. The GBAF is now being supported by Corporate level and Committee level risk registers and the Committee received an update at its February meeting on the development of these risk registers and the committees' discussions in these areas.

2.16 A revised risk management strategy has been developed, which clearly defines the role of the Audit and Governance committee in maintaining a primary overview of the CCG's risk management arrangements, providing assurance to the Governing Body that the committee's reviews of risks appropriately support the population of the GBAF, which can then be used as an effective management tool for the organisation. The committee also noted at the February meeting that the follow up review by the Internal Audit service recognised the significant steps forward taken by the CCG in this area during the year. Whilst work remains to ensure that the new arrangements are fully embedded, the committee has been assured that plans are in place to ensure that the CCG continues to effectively identify, mitigate and manage the risks it has identified.

2.17 One of the ways in which the committee gains assurance that risks are being effectively managed is through the use of deep dives into particular areas of risk. In July the committee undertook a brief deep dive into the CCG's mitigation against an identified risk of cyber attacks, using the WannaCry virus attack as a case study. The risk of cyber attack is detailed on the CCG's risk register as a relatively low risk due to significant work undertaken in conjunction with Royal Wolverhampton Trust (which provides IT services across the health economy) to mitigate against the impact of risks. The briefing on the cyber attack demonstrated the effectiveness of

the measures in place, which had ensured that the IT estate across Wolverhampton was not affected by the virus attack and patients were not impacted as they had been in other areas. The committee were assured that the process of identifying, assessing and mitigating the risk was demonstrably appropriate.

2.18 Other areas of internal control considered by the committee include Counter Fraud and Security Management, plans for which were agreed at the beginning of the year and then update on progress provided at each quarterly meeting. No significant issues have been identified during the year and the committee will continue to maintain an overview of these areas through the year.

Accounting Matters

2.19 The most significant work the committee undertakes in relation to accounting matters is to scrutinise the preparation of the CCG's annual accounts and reporting. A draft version of the annual accounts was presented to the April committee and the final version was recommended to the Governing Body for sign off in May 2017. As part of this process, the CCG were given assurance around a number of specific elements of the technical accounting arrangements. The committee, in recommending the accounts noted the work undertaken as well as the unqualified opinion issued by the External Auditors and assurance from NHS England.

2.20 The committee's terms of reference set out some specific responsibilities for reviewing issues such as special payments, losses and the use of waivers and or breaches of the CCG's Detailed or Prime Financial Policies. The committee also maintains an overview of receivables and payables greater than £10,000 and over 6 months old. The Chief Finance Officer reports on these issues at each of the committees meetings. No significant concerns have been raised as a consequence of these reports, however the committee have asked that details of contracts renewed by the use of waivers are reviewed to ensure appropriate procurement mechanisms are used.

3. Review of Effectiveness

3.1 As in previous years, the committee has undertaken a review of its effectiveness using a self-assessment tool for Audit Committees developed by the Department for the Environment, Food and Rural Affairs. This review highlights areas for the committee to consider to determine whether it meets its roles and responsibilities effectively, including the structure and content of the committee's meetings, the link with the CCG's Governing Body and support available to members of the committee.

3.2 The self-assessment has identified that the committee has a clear role that is understood by both the members and wider organisation, that the committee is sighted on CCG wide issues and has adequate time available to conduct their role in a meaningful way. It was noted that, due to the timing of meetings and the national deadline for the submission of accounts, the committee had had a more limited opportunity to review the annual accounts.

3.3 Areas that the review identified for further work in the upcoming year included appraisals for committee members and continual review of committee effectiveness. The Chair has undertaken to discuss arrangements for appraisals for both committee members and the wider Governing Body with the Governing Body Chair during the

year and this will be discussed through the remuneration committee. The committee will consider approaches to reviews of its own effectiveness throughout the year, including review at meetings.

4. Conclusions

4.1 The committee believes that the evidence set out above demonstrates that it has effectively met the requirements of its terms of reference. In particular, the committee's focus on addressing previously identified issues with risk management arrangements ensures that it continues to make a positive contribution to the CCG's governance and internal control arrangements.

4.2 As the CCG continues to operate in a changing environment, the committee will continue to ensure it provides the appropriate assurance that the CCG continues to meet its statutory duties in the most effective ways possible. As the CCG explores options for different ways of discharging its duties through both STP wide collaboration and more locally based expressions of Place Based Care the committee will continue to play a key role in ensuring the implications for both broader governance of the CCG and providing assurance through audit mechanisms remain high on the agenda. This will include continued and increasing closer working with our colleagues in other CCGs through the mechanisms we have already begun to establish.

Appendix 1 – Attendance at Meetings

Attendee		Meetings Attended (of those required)	Notes
Committee Members	Peter Price (Chair)	4 of 4	Joined the Committee in May 2017
	Les Trigg	5 of 5	
	Dean Cullis	5 of 5	
	Jim Oatridge	4 of 5	Attended May and July meetings in capacity as Interim Chair of the CCG
CCG Staff	Claire Skidmore (Chief Finance and Operating Officer)	2 of 2	Left the CCG in May 2017
	Tony Gallagher (Chief Finance Officer)	3 of 3	Joined the CCG in June 2017
	Peter McKenzie (Corporate Operations Manager)	4 of 5	
	Steve Forsyth (Head of Quality & Risk)	1 of 2	
	Maria Tongue (Head of Financial Resources)	3 of 3	
External Attendees	Alison Breadon (Head of Internal Audit, PwC)	1 of 1	
	Joanna Watson (Senior Manager, PwC)	5 of 5	
	Neil Mohan (Senior Manager LCFS, PwC)	4 of 4	
	Shaun Grayson (LSMS, CWAS)	2 of 3	
	Hassan Rohimun (Executive Director, Ernst Young)	1 of 1	EY were the CCG's External Auditors for 2016/17
	V Sarjan (Audit Manager, Ernst Young)	3 of 3	
	T Faniadou (Audit Senior, Ernst Young)	1 of 1	
	Mark Stocks (Audit Partner, Grant Thornton)	2 of 3	Grant Thornton are the CCG's External Auditors for 2017/18
	Jim McLarnon (Audit Manager, Grant Thornton)	1 of 1	

1. Appendix 2 - AGC Duties (Extract from TOR)

The AGC 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 will deliver this remit in the context of the group's priorities, as they emerge and develop, and the risks associated with achieving them.

The AGC shall critically review the group's financial reporting and internal control principles and ensure that an appropriate relationship with both internal and external auditors is maintained.

The specific duties required of the AGC are:

i) reviewing the group's adherence to the principles of good governance (constitution 4.5);
ii) monitoring the group's performance in delivering:
    (a) the duty to act effectively, efficiently and economically (constitution 5.2.3);
    (b) its general financial duties as regards expenditure not exceeding allotments and use of resources, both total and specified types, not exceeding specified amounts (constitution 5.3.1 - 5.3.3);
iii) monitoring the group's performance in delivering the duties relating to:
    (a) acting consistently with the promotion of a comprehensive health service and the mandate issued for each financial year by the Secretary of State to NHS England (constitution 5.1.2(a));
    (b) obtaining appropriate advice as part of processes for potential or actual changes to commissioning arrangements (constitution 5.2.9(b)).
iv) reviewing the reasonableness of any decision to suspend Standing Orders and considering reports on any suspension of Standing Orders at any meeting (SO 3.9) and any non-compliance with Prime Financial Policies, scrutinising any proposed changes thereto and determining any referring action or ratification (PFP 1.2.1);
v) reviewing the group's arrangements to manage all risks and receive appropriate assurance thereon through an integrated governance framework;
vi) satisfying itself that there is an effective internal audit service (PFP3) and adequate arrangements for countering fraud (PFP4), reviewing the work and findings of the external auditors and approving any changes to the provision of delivery of assurance services to the group (PFP3.4(b);
vii) reviewing the annual report and financial statements before submission to the governing body and the group; and
viii) scrutinising any proposed changes to Prime Financial Policies (PFP 1.5.1).

Integrated governance, risk management and internal control

The AGC will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the group's activities that support the achievement of the group's objectives.

The AGC will be responsible for reviewing and approving the group's overall strategy for Risk Management and reporting to the Governing Body on its effectiveness.

It's work will dovetail with that of the other Governing Body committees, which the group has established in order to seek assurance that robust arrangements are in place for

- Financial and performance management arrangements;
- Effective arrangements for commissioning healthcare services (including those delegated from NHS England in respect of Primary Care); and
- monitoring clinical quality to ensure patient safety.

Each of the committees has a specific role in these areas and monitor and manage the risks associated with these areas on behalf of the Governing Body. The AGC will review the arrangements in place to support this and in particular, will review the adequacy and effectiveness of:

- all risk and control related disclosure statements, (in particular the governance statement), together with any appropriate independent assurances, prior to endorsement by the group;
- underlying assurance processes, including the work of the other committees of the governing body, that indicate the degree of achievement of group objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification;
- policies and procedures for all work related to fraud and corruption as set out in Secretary of State's directions and as required by NHS Protect.

In carrying out this work the AGC will primarily utilise the work of internal audit, external audit and other assurance functions but will not be limited to these sources.

It will also seek reports and assurances from those working for and providing services to the group as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the AGC's use of an effective assurance

framework to guide its work and that of the audit and assurance functions that report to it.

Internal audit

The AGC will ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to AGC, the Accountable Officer and the group. This will be achieved through:

- consideration of the provision of the internal audit service, its cost and any questions of resignation and dismissal;
- review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
- considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise use of audit resources;
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the group;
- an annual review of the effectiveness and the level of satisfaction with the services of internal audit;
- approval of the internal audit charter.

External audit

The AGC will review the work and findings of the external auditors and consider the implications of their reports and any management responses to their work. This will be achieved by:

- consideration of the performance of the external auditors, as far as the rules governing the appointment permit;
- discussion and agreement with the external auditors, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy;
- discussion with the external auditors of their local evaluation of audit risks and assessment of the group and associated impact on the audit fee;
- a review of all external audit reports including the report to those charged with governance, agreement of the annual audit letter before its submission to the group and work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other assurance functions

The AGC shall review the findings of other significant assurance functions, both internal and external, including regulators and inspectors, and consider the implications for the governance of the group. The AGC will approve any changes to the provision or delivery of assurance services to the group (PFP 3.4(b)).

The AGC has full authority to commission any reports or surveys it deems necessary to help it fulfill its obligations, with the necessary funding to be agreed with the Chief Finance Officer by the AGC's Chair.

Counter fraud

The AGC shall satisfy itself that the group has adequate arrangements in place for countering fraud, including the need to work effectively with NHS Protect, approve the counter fraud work plan and review the outcomes of counter fraud work (PFP 4.2 – 4.3).

Management

The AGC shall, as appropriate, request and review reports giving positive assurances or identifying risks from senior managers and those responsible for providing services to the group on the overall arrangements for governance, risk management and internal control

Financial reporting

The AGC shall monitor the integrity of the financial statements of the group and any formal announcements relating to the group's financial performance.

The committee shall ensure that the systems for financial reporting to the group, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the group.

The AGC shall review the annual report and financial statements before submission to the governing body and the group, focusing particularly on:

- wording in the governance statement and other disclosures relevant to the terms of reference of the AGC ;
- changes in, and compliance with, accounting policies, practices and estimation techniques;
- unadjusted mis-statements in the financial statements;
- significant judgements in preparing of the financial statements;
- significant adjustments resulting from the audit;
- agreement of the letter of representation before it is signed, on behalf of the governing body; and
- qualitative aspects of financial reporting.

NHS
Wolverhampton
Clinical Commissioning Group

ANNUAL REPORT

Commissioning Committee 2017/2018

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RELATED DOCUMENTS

These documents will provide additional information:

REF NUMBER	DOCUMENT REFERENCE NUMBER	TITLE	VERSION

Contents

1. Introduction

1.1 This report sets out the work undertaken by the Commissioning Committee during the 207/18 financial year. It has been prepared to provide assurance to the Governing Body that the Committee is meeting the duties assigned to it and performing effectively.

1.2 The Committee has been established by the CCG's Governing Body to support the Governing Body, the Director of Strategy and Transformation and Executive Nurse in meeting the group's responsibilities as a commissioner of healthcare, specifically:

- acting consistently with the promotion of a comprehensive health service and the mandate issued for each financial year by the Secretary of State to the NHS England Commissioning Board, for which the Committee has developed a Commissioning Policy;
- securing continuous improvement in the quality of services;
- co-ordinating the work of the group as appropriate with NHS England, other clinical commissioning groups, local providers of services, local authorities, patients and their carers, the voluntary sector and others to develop robust commissioning plans.

1.3 The evidence contained in this report will be shared with the CCG's Governing Body and also will be used to support the content of the organisations' Annual Governance Statement.

1.4 The committee's membership requirements are set out in its Terms of Reference, stating that the Committee must be chaired by an elected GP member of the Governing Body, must include the Chief Finance Officer and can include other members of the Governing Body and employees of the group (including a commissioner). The members of the Committee during the year have been:-

- Dr Julian Morgans (until October) - Elected Member of the Governing Body (Chair)
- Dr Manjit Kainth (from November) - Elected Member of the Governing Body (Chair)
- Dr Rashi Gulati (from November) - Elected Member of the Governing Body
- Manjeet Garcha (until September) - Executive Nurse
- Sally Roberts (from February) - Executive Nurse
- Juliet Grainger - Local Authority
- Paul Smith (until June) - Local Authority
- Sarah Smith (from July) - Local Authority
- Steven Marshall - Director of Strategy and Transformation
- Cyril Randles - Patient Representative
- Malcolm Reynolds - Patient Representative
- Claire Skidmore (until May) - Chief Finance and Operating Officer
- Tony Gallagher (from June) - Chief Finance Officer
- Vic Middlemiss - Head of Contracting & Procurement

1.5 A number of longstanding members of the committee have left during the year. Claire Skidmore, Chief Finance and Operating Officer left the CCG in June 2017 to take up the role of Chief Finance Officer at Shropshire CCG and Manjeet Garcha, Executive Nurse retired from her role in October 2017. Most significantly, Dr Julian Morgans, who has chaired the Committee since 2015, stood down from the

Governing Body in October 2017. Dr Morgans has made a valuable contribution to the work of the CCG during his tenure on the Governing Body, acting as clinical lead for Urgent Care as well as his role as Chair of Commissioning Committee. The Committee wished him well in his future endeavours as well as welcoming Dr Manjit Kainth as his successor in November.

1.6 The Committee met on the following occasions during the financial year:

- 27 April 2017
- 25 May 2017
- 22 June 2017
- 27 July 2017
- 24 August 2017
- 28 September 2017
- 26 October 2017
- 23 November 2017
- 25 January 2018
- 22 February 2018
- 29 March 2018

Details of the attendance at all of these meetings are enclosed at Appendix 1 for information.

2. Committee Responsibilities

2.1 As highlighted above, the Committee is appointed by and is accountable to the Governing Body. The details of this are set out in the group's Constitution at Paragraph 6.9.5 e) which include the key duties outlined above. In order to fulfil this role, the detailed Terms of Reference for the Committee appended to the constitution include a number of specific responsibilities that guide the Committee's work. These are listed in full in Appendix 2, but can be summarised into the following broad themes:-

- Developing and reviewing commissioning strategies and policies
- Contracting
- Service Specifications and Procurement
- Service Review

2.2 Section 3 of this report details the committee's work during the year against these four themes. As in previous years, this evidence is being used to conduct an assessment of how effectively the committee has met its duties during 2017/18.

3. Work undertaken

3.1 This section sets out a summary of the Committee's work at meetings. Due to the nature of the Committee's work, a number of items have been considered at multiple meetings so, this section describes these on an issue by issue basis rather than providing a chronological account of the Committee meetings.

Developing and Reviewing Commissioning Strategies and Policies

3.2 In previous years, this has formed a significant element of the Committee's work as the CCG, as a relatively new organisation, established approaches to commissioning in key areas. Work has been undertaken on the development of commissioning intentions, which set out the CCG's key priorities in each area and the approach to commissioning services to address them.

3.3 With changes in NHS Planning Guidance, and the establishment of two year contracts with providers based on the Commissioning intentions developed in 2016, the committee has not needed to undertake similarly detailed work on commissioning intentions during 2017/18. The committee has maintained an overview of the changes in contracts with providers based on refreshed national planning guidance throughout the contracting round.

3.4 The CCG is working closely with GPs and providers across Wolverhampton to develop a much more integrated health and social care system, which will have a significant impact on commissioning strategies and the way in which the CCG manages its contractual relationship with providers. In addition, plans for closer collaboration with the other CCGs in the Black Country on strategic commissioning continue to progress and will have a consequent impact on the CCG's own commissioning approaches. These issues are likely to impact significantly on the committee in upcoming years.

3.5 Specific work undertaken by the committee in this area during the year has focussed on understanding the impact of existing plans and strategies. This has included the strategy for Child and Adolescent Mental Health Services (CAMHS) that the committee was involved in reviewing in 2016/17 and an overview of the CCG's approach to managing projects.

3.6 Following a piece of work to review the process by which the CCG provided grants to third sector bodies, the Committee supported an approach to develop a process to evaluate proposals from the third sector. This process aimed to provide a degree of proportionality and the committee supported the outcome of the process in July, which resulted in a number of grants being made to health related third sector organisations. The committee also received an update on proposals to develop a new approach to commissioning for Local Authority Public Health services.

Contracting

3.7 The committee has continued its work in this area by receiving assurance at each meeting on the CCG's management of its contracts in the form of an update report. These reports from the Head of Contracting and Procurement provide details of contractual performance and actions taken in response through Contract Management meetings and the use of contractual sanctions. The reports focus on the CCG's main providers Royal Wolverhampton Trust (RWT) and Black Country Partnership Foundation Trust (BCPFT) but also provide details of any significant issues with the CCG's other providers by exception.

3.8 At RWT, the committee has noted that the most significant performance issues have included A&E waiting times and 62-day cancer waits as well as areas of overperformance in elements of activity. The reports have detailed actions taken through the CCG's contract review meetings as well as the use of contractual sanctions, including how these sanctions have been reinvested into service delivery to support performance improvements. The committee has also been updated on changes to reporting processes to improve data quality that supports contract review. This included a specific piece of work around the coding of Sepsis, which followed a national change of guidance and details of the impact of transfers in activity from Walsall Manor.

3.9 Issues relating to BCPFT have included updates on work between the Trust and RWT to support patients with mental health problems attending A&E. The committee

have also been updated on joint work to improve data quality and progress with developing a contract variation for 2018/19.

3.10 Other contractual matters brought to the committee's attention have included performance concerns in relation to Non-Emergency Patient Transport services, queries about thresholds for elective activity at the Nuffield and details of activity from the CCG's new Musculoskeletal Services provider. Most significantly, the committee have been kept appraised of the contractual situation at the Vocare Urgent Care Centre following quality concerns, including a negative CQC rating. The updates to the Committee have included the work to establish an improvement board to support Vocare to address issues and details of the assurance provided to the Governing Body.

Service Specifications and Procurement

3.11 As in previous years, this has been a significant element of the committee's work, with a number of specifications being considered at different points throughout the year before moving towards a procurement. This has included changes to existing services, such as the community falls service which was considered in April and November and services for patients with Sickle Cell and Thalassemia. Later in the year, the committee has also reviewed specifications associated with medicines management and high risk drugs. The committee has commented on the specifications as well as endorsing approaches to moving towards procurement.

3.12 The Committee has also considered a number of specifications for new services, including a number designed to support the CCG's strategy to move care closer to home through greater delivery in primary care. New services supported in Primary Care have included an online resource to support self-care called Sound Doctor that enables patients to access videos and other information about specific conditions. The committee has also approved a specification and the procurement approach for a service providing counselling services in primary care. The aim of this approach is to enable patients to access appropriate interventions at an earlier stage to reduce the need to rely on more acute services in the future. The committee has also endorsed approaches to commissioning additional services for Children and Young people, particularly in relation to emotional health and wellbeing support to address gaps in current provision in line with the CAMHS strategy.

3.13 A number of business cases for service specifications have been considered throughout the year. This has included changes in the use of a number of drugs and procedures based on guidance from the National Institute for Health and Care Excellence, which the committee has supported. The committee also considered a specific business case associated with Atrial Fibrillation and establishing a community based service however, following detailed consideration, the committee did not feel that the evidence in support of this service was sufficient to support it.

3.14 In conjunction with work on developing Service Specifications, the committee's work in this area includes overseeing procurement work and making recommendations to the Governing Body. The Head of Contracting and Procurement has provided an update on these issues on a quarterly basis. This has included details of procurement work for Eye Care services and work the CCG had undertaken on behalf of the West Midlands Combined Authority to commission a nationally developed pilot research project supporting people with specific health conditions into employment. The CCG was acting as a 'host' organisation for this project and acting as the contracting body as a result. The committee was also kept informed of work to change the contractual arrangements for a jointly commissioned nursing

home service with the local authority. The committee also agreed to support the extension a number of contracts where there were legitimate and extenuating circumstances to do so.

Service Review

3.15 The committee's work on service specification and procurement has, in many cases been informed by detailed work to review services to identify gaps and potential improvements. Specific examples of this have included the work on services for patients with Sickle Cell and Thalassemia and a specialist nursing home jointly commissioned with the local authority.

3.16 Following work conducted last year, the committee has also reviewed the impact of a number of new services introduced. This has included the use of Step Up beds managed by the Rapid Intervention Team to support patients who are at risk of admission to hospital in the community. This service has received excellent feedback from GPs and demonstrated significant impact in avoiding admissions and the committee supported its continuation. The community also reviewed the work of the Primary Care In reach team that worked in Care Homes to provide additional support to patients to preventatively avoid admissions. Following a detailed debate on the impact of these services, the committee agreed to extend this team to work across 20 care homes with significant numbers of emergency admissions.

3.17 In line with the CCG's strategy, the committee has also reviewed services in primary care, including a pilot project to provide social prescribing services. This project, commissioned with the voluntary sector, aimed to improve patient's health and wellbeing by reducing isolation and promoting independence. The committee recognised that positive feedback had been received but that further evidence was required for a comprehensive evaluation and supported an extension of the pilot project for this purpose.

3.18 Individual pieces of work conducted in response to feedback from committee members or as a result of issues raised by the committee's other reporting have included feedback on dermatology and Musculoskeletal services. Due to the nature of this work, some of the committee's work on service review has been conducted in private session.

Risk Management

3.19 In common with the CCG's other committees, the committee has taken on a broader role in the CCG's risk management arrangements. The committee reviews risks that have been assigned to it on a monthly basis, assessing whether the identified levels of risk and actions taken to address them are appropriate. The committee have also escalated risks to the Governing Body where they feel this is appropriate to do so.

4. Conclusions

4.1 The committee believes that the evidence presented above demonstrates both the breadth of its work and that it has continued to work effectively to meet its terms of reference. The committee has had a busy and productive year and is continuing to provide vital support to the CCG in ensuring it is able to meet its statutory duty to commission a comprehensive health service for the patients in Wolverhampton.

4.2 The committee recognises that closer working both with providers and other CCGs will see changes in the way in which the CCG will commission services in the future. This will include moving towards approaches based on commissioning for outcomes and new ways of contracting. The committee looks forward to continuing to provide

support to the CCG to deliver its responsibilities as work to develop these approaches continues.

Appendix 1 – Attendance at Meetings

Appendix 2 – Commissioning Committee Duties (Extract from TOR)

The CC is accountable to the governing body and its remit is to provide the governing body, Director of Strategy and Solutions and Executive Nurse, amongst others, with support in meeting the duties and responsibilities of the group as a commissioner of healthcare services, specifically:

- acting consistently with the promotion of a comprehensive health service and the mandate issued for each financial year by the Secretary of State to NHS England , for which the CC has developed a Commissioning Policy;
- securing continuous improvement in the quality of services;
- co-ordinating the work of the group as appropriate with NHS England , other clinical commissioning groups, local providers of services, local authorities, patients and their carers, the voluntary sector and others to develop robust commissioning plans..

It delivers these duties by developing and delivering annual work programmes giving appropriate focus to the following:

- develop the commissioning strategy, commissioning plans and annual commissioning intentions, anticipating and adapting as required for national and international policy, the group's safeguarding and other statutory responsibilities, local and national requirements and patient expectations;
- oversee the annual contracting processes and any other programmes of healthcare service procurement;
- review of commissioning policies;
- develop service specifications for the commissioning of healthcare services;
- consider service and system reviews and develop appropriate strategies across the health and social care economy to address any identified issues;
- review progress against commissioning strategies and plans to ensure achievement of objectives within agreed timescales;
- make recommendations as necessary to the governing body on the remedial actions to be taken with regard to key risks and issues associated with the commissioning portfolio.

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NHS
Wolverhampton
Clinical Commissioning Group

ANNUAL REPORT

Finance and Performance Committee
2017/2018

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Contents

1. Introduction

1.1 This report sets out the work undertaken by the Finance and Performance committee during the 2017/18 financial year. It has been produced in order to demonstrate to the Governing Body has met the duties assigned to it by the Governing Body in its terms of reference.

1.2 The committee has been established by the CCG's Governing Body to provide assurance on issues related to the finance and performance of the group. Its main purpose is to monitor, on behalf of the Governing Body, how the group is meeting its statutory duties to act effectively, efficiently and economically and to reduce inequalities.

1.3 The evidence contained in this report forms part of the Committee's review of its effectiveness and will be shared with the CCG's Governing Body and also will be used to support the content of the Accountable Officer's Annual Governance Statement, which is a key part of the organisation's Annual Report.

1.4 As highlighted in last years' Annual report, the membership of the Committee has changed as a result of broader changes in the Governing Body. This has seen Les Trigg joining the Committee as Chair, firstly on an interim basis and then permanently from October 2017. The committee also welcomed Dr Mohammad Asghar, who was elected on to the CCG's Governing Body in October 2017 and Tony Gallagher, who joined the CCG as Chief Finance Officer as a joint appointment with his existing role at Walsall CCG in June 2018. The members of the committee during the year have has been:-

- Les Trigg (Chair) - Lay Member for Finance and Performance
- Dr David Bush - Elected Member of the Governing Body
- Dr Mohammad Asghar - Elected Member of the Governing Body
- Tony Gallagher - Chief Finance Officer
- Mike Hastings - Director of Operations
- Steven Marshall - Director of Strategy and Transformation

The previous chair, Peter Price took the Chair for the Committee meeting in April and Claire Skidmore, the previous Chief Finance and Operating Officer attended meetings in April and May prior to her departure.

1.5 The committee met on the following occasions during the financial year:

- 25 April 2017
- 30 May 2017
- 27 June 2017
- 25 July 2017
- 29 August 2017
- 26 September 2017
- 31 October 2017
- 28 November 2017
- 30 January 2018
- 27 February 2018
- 28 March 2018

Details of the attendance at all of these meetings are enclosed at Appendix 1 for information.

2. Committee Responsibilities

2.1 As highlighted above, the committee is appointed by and is accountable to the Governing Body. The details of this are set out in the group's Constitution at Paragraph 6.9.5 d) which include the key duties outlined above. In order to fulfil this role, the detailed terms of reference for the committee appended to the constitution include a number of specific responsibilities that guide the committee's work. These are listed in full in Appendix 2, but can be summarised into the following broad themes:-

- Monitoring Financial Performance and Efficiency
- Monitoring Performance and Performance Management
- Specific Responsibilities under the Group's Prime Financial Policies
- Monitoring the group's work on reducing Inequalities

2.2 Section 3 of this report details the committee's work during the year against these four themes. As in previous years, this review of work is the most significant evidence in determining how the Committee has met its defined duties and identifying any areas for future improvements.

3. Work undertaken

3.1 This section sets out a summary of the committee's work at meetings. As the committee schedule of meetings is monthly, it organises its work so that there are a number of agenda items that are received at every meeting. By their nature, these regular reports include work against more than one of the themes detailed in the section above. Where this has occurred, it is highlighted throughout the report.

Financial Performance and Efficiency

3.2 The Committee's primary purpose is to provide the Governing Body with assurance that key statutory duties for the CCG are being met. In relation to financial matters, this the committee gains this assurance via monthly reports from the Chief Finance Officer. These reports have provided the committee with an overview of the CCG's current financial position, details of the forecast position at year end and any significant issues identified that have financial implications. The Committee uses the detail from these reports to give assurance to the Governing Body that financial duties are being met effectively.

3.3 Assurance has been gained throughout the year that the CCG has remained on track to meet relevant financial targets with the committee scrutinising the work of the management team to address issues that have arisen during the year. The Committee has recognised that the CCG, in common with NHS organisations across the country, faces increasing pressures in managing challenging financial circumstances and highlighted the work of management to deliver the CCG's financial plans throughout the year.

3.4 Issues that the committee have recognised throughout the year have included increased pressure on the GP prescribing budget due to a number of factors, including the availability of particular drugs. The committee have been kept informed of the CCG's work to address this, including working with pharmacists to identify solutions to address overspends. The committee have also been advised on ongoing discussions about a disputed invoice with RWT from 2016/17.

3.5 One of the areas that has a significant impact on the CCG's financial performance is the development of Quality, Innovation, Prevention and Productivity (QIPP) plans. The Chief Finance Officer's regular reports to the committee gave detailed updates on the CCG's progress, noting efforts to identify schemes to address a gap in plans throughout the year. In August the committee were informed of changes to the CCG's governance structures to streamline reporting process by reducing the number of programme boards and introducing direct reporting into the committee itself. These arrangements will be reviewed early in the new year.

Performance Monitoring and Management

3.6 In a similar way to its approach to gaining assurance on financial matters, the committee works to understand performance issues facing the CCG primarily through regular reporting on key areas. The Director of Operations provides a report on key performance management matters, including details of performance against key indicators from the NHS Constitution and the Head of Contracting and Procurement provides a report on activity and action associated with the CCG's contracts with provider organisations.

3.7 Whilst providing an overall overview of performance and contracting matters, these reports focus on highlighting areas, by exception, of potential concern about performance and outline action taken to address them. Details are drawn from a variety of sources, including intelligence from contract review activities and the providers own reporting mechanisms. The committee has been able to use these reports to seek further assurance about management actions where required and escalate issues, where necessary, to the Governing Body. In particular, the committee has noted performance issues associated with A&E waits (which has been a recognised national issue) and 62 Day Cancer waits. The Committee has been given assurance on the work with providers to address these issues, including the use of contractual sanctions where appropriate.

3.8 Following its work last year to review the CCG's plans and processes for using robust data to support its work, the committee has been kept up to date on ways in which the CCG has worked with providers to address data quality issues throughout the year. This has included querying details from exception reporting processes at Royal Wolverhampton Trust (RWT) and working closely with Black Country Partnership Foundation Trust to address discrepancies in performance figures. The committee has been assured that this proactive approach enables the CCG to continue to triangulate robust performance data with other intelligence to hold providers to account in a positive manner.

Responsibilities under Prime Financial Policies

3.9 The committee has a number of defined roles within the group's Prime Financial Policies. The principal duty is to support the Chief Finance Officer in the development of the group's financial plans. In line with defined national time lines, the committee has discharged this duty primarily by taking a long term view of the CCG's financial position through the Chief Finance Officers reporting and a detailed consideration of a draft plan in February 2018.

3.10 The Committee recognised the work undertaken to develop a draft finance plan which met the nationally defined metrics. In particular, the committee noted that, detailed mitigations had been considered and included to manage all of the risks

identified in the plan, leaving a net nil risk position. The Committee queried elements of the plan before recommending its adoption by the Governing Body, which considered and agreed the committee's recommendation in April 2018.

3.11 In addition to discharging its operational duties within the CCG's financial policies, the committee is also responsible for developing and suggesting improvements to the policies themselves. Following reviews in previous years, the committee has not undertaken any work on this during 2017/18 but plans to do so in 2018/19.

Monitoring Work on Reducing Inequalities

3.12 The Committee discharges this responsibility primarily by ensuring that addressing these issues is built into its ongoing review of performance across the healthcare system. The committee is kept aware of ongoing work to address inequalities and, as part of its role in the CCG's risk management arrangements, the committee reviews risks assigned to it which impact on health inequalities.

3.13 No specific concerns have been raised in relation to health inequalities during the year through the Committee's reporting processes however, the committee has identified and discussed the potential risk to health inequalities of RWT taking on additional activity as a result of service changes across the Black Country. The committee will continue its monitoring approach to these issues throughout 2018/19.

Risk Management

3.14 In common with the CCG's other committees, the committee has taken on a broader role in the CCG's risk management arrangements. The committee reviews risks that have been assigned to it on a monthly basis, assessing whether the identified levels of risk and actions taken to address them are appropriate. The committee have also escalated risks to the Governing Body where they feel this is appropriate to do so.

4. Conclusions

4.1 The Committee plays a key role in providing assurance to the Governing Body on the CCG's continued financial and operational performance. The work it has undertaken this year demonstrates that it is continuing to meet its terms of reference by providing advice and support, particularly to the Chief Finance Officer, to ensure the CCG meets its statutory financial duties.

4.2 The committee remains committed to continuous improvement and, in this spirit has worked during the year to ensure that the reporting mechanisms in place to enable it to discharge its duties are effective. This has involved greater use of executive summaries to ensure that committee discussion is focussed appropriately on the most pertinent areas.

4.3 The committee believes that the evidence presented in this report clearly demonstrates that it remains effective and looks forward to continuing its work in the upcoming year.

Appendix 1 – Attendance at Meetings

1. Appendix 2 – F&PC Duties (Extract from TOR)

The specific duties required of the FPC are:

- to support the Chief Finance Officer in the delivery of the general financial duties (constitution 5.3.1 – 5.3.3);
- to receive reports from the group's representative on the Wolverhampton Health and Wellbeing Board with regard to development of the joint assessments and strategies and delivery of the latter (constitution 5.1.2(c)(ii));
- to monitor the group's delivery of the duty to act effectively, efficiently and economically (constitution 5.2.3);
- to monitor the group's delivery of the duty to have regard to the need to reduce inequalities (constitution 5.2.6);
- review the Chief Finance Officer's proposals for any changes to the Prime Financial Policies prior to scrutiny of them by the Audit and Governance Committee (PFP 1.5.1)
- approval of detailed financial policies (PFP 1.1.3);
- to consider reports from the Chief Finance Officer regarding significant variances from budgeted performance (PFP 7.3) and approve any changes to budgets not significant enough to require approval by the governing body (PFP 7.4);
- to consider reports from management regarding significant variances from non-financial performance targets;
- agree the Chief Finance Officer's timetable for producing the annual accounts and report (PFP 8.1(a));
- approve the group's overall banking arrangements (PFP 11.2);
- receive reports detailing actual and forecast expenditure and activity for all healthcare contracts (PFP14.3).

NHS
Wolverhampton
Clinical Commissioning Group

ANNUAL REPORT

Quality and Safety Committee
2017/2018

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RELATED DOCUMENTS

These documents will provide additional information:

REF NUMBER	DOCUMENT REFERENCE NUMBER	TITLE	VERSION

Contents

1. Introduction

1.1 This report sets out the work undertaken by the Quality and Safety Committee during the 2017/18 financial year. This demonstrates how the committee has met the responsibilities set out for it by the Governing Body in the Clinical Commissioning Group's constitution.

1.2 The Committee has been established by the CCG's Governing Body to support the Governing Body in meeting a number of the group's statutory responsibilities, specifically:

- Promoting a comprehensive health service;
- Securing public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements;
- Promoting awareness of and securing health services that are consistent with the NHS Constitution;
- Assisting NHS England in securing improvements in Primary Medical Services;
- Supporting Patient choice

1.3 The evidence contained in this report focuses on how the committee has met these duties and will be shared with the CCG's Governing Body and also will be used to support the content of the organisations' Annual Governance Statement.

1.4 The committee's membership requirements are set out in its terms of reference, stating that the committee must be chaired by an elected GP member of the Governing Body, must include the Executive Nurse and the Secondary Care Clinician, representatives of member practices, employees of the group, individuals who reflect the wider local multi-professional clinical and social care community and a patient /carer representative. The committee values the broad perspective offered by its diverse membership, benefiting from both clinical and professional viewpoints as well as the insight offered by the patient representatives. The members of the committee during the year have been:-

- Dr Rajshree Rajcholan - Elected Member of the Governing Body (Chair)
- Dr Julian Parkes - Elected Member of the Governing Body (from November 2017)
- Steven Forsyth - CCG Employee (until January 2018)
- Mr Amarbaj Chandock - Secondary Care Clinician (From June 2017)
- Manjeet Garcha - Executive Nurse (Until October 2017)
- Sally Roberts - Executive Nurse (From February 2018)
- Marlene Lambeth - Patient Representative
- Annette Lawrence - CCG Employee
- Jim Oatridge - Governing Body Lay Member
- Sukhdip Parvez - CCG Employee
- Pat Roberts - Governing Body Lay Member for PPI (until October 2017)
- Peter Price - Governing Body Lay Member for Governance (from June 2017)
- Kerry Walters - Wider Health and Social Care Representative
- Alicia Price - Patient Representative (from October 2017)

1.5 The Committee has seen a number of changes in its membership during the year, saying goodbye to Manjeet Garcha, Steven Forsyth and Pat Roberts. Manjeet served as the CCG's Executive Director for Nursing and Quality since establishment and retired in October following a long and distinguished career in the NHS. Pat has also served the CCG since establishment as the Lay Member for public involvement, working tirelessly to champion patient concerns across the CCG and retired in October. Steven joined the CCG in 2016 as Head of Quality and Risk and left the CCG in January 2018 to take up a role as Area Nurse Director for Betsi Cadwaladr University Health Board in North Wales. The Committee has welcomed Amarbaj Chandock (Secondary Care Consultant), Sally Roberts (Executive Nurse), Dr Julian Parkes (Elected GP Governing Body Member), Alicia Price (Patient Representative) and Peter Price (Lay Member) as new members of the committee during the year.

1.6 The committee met on the following occasions during the financial year:

- 11 April 2017
- 9 May 2017
- 13 June 2017
- 11 July 2017
- 8 August 2017
- 12 September 2017
- 10 October 2017
- 14 November 2017
- 12 December 2017
- 9 January 2018
- 13 February 2018
- 13 March 2018

Details of the attendance at all of these meetings are enclosed at Appendix 1 for information.

2. Committee Responsibilities

2.1 As highlighted above, the committee is appointed by and is accountable to the Governing Body. The details of this are set out in the group's Constitution at Paragraph 6.9.5 c) which include the key duties outlined above. In order to fulfil this role, the detailed terms of reference for the committee appended to the constitution include a number of specific responsibilities that guide the committee's work. These are listed in full in Appendix 2, but can be summarised into the following broad themes:-

- Quality and Patient Safety Issues;
- Risk Management and Assurance;
- Monitoring the Group's arrangements for meeting statutory duties (including Information Governance, Equality and Public Involvement); and
- Safeguarding

2.2 Section 3 of this report details the committee's work during the year against these four themes. As part of the group's commitment to continuous improvement, this approach to monitoring the committee's work will form part of its assessment of effectiveness during 2017/18. A draft of this report is being considered by the Committee at its May meeting, giving members the opportunity to feed their views on how well the duties of the Committee have been discharged.

3. Work undertaken

3.1 This section sets out a summary of the committee's work at meetings as part of the committee's assessment of its effectiveness. Further detail on specific quality issues

will also be included in the CCG's Annual Report and has been reported to the Governing Body throughout the year.

Quality and Patient Safety Issues

3.2 The most significant duty the committee has is to support work to monitor the quality of the services provided for our patient population. It performs this duty in order to provide assurance to the Governing Body that services are safe and effective and escalates any significant issues arising from its work. Work on this theme therefore takes up a significant portion of the committee's work programme during the year. The Quality and Risk team provide the committee with detailed reports at each monthly meeting outlining quality performance at each of the CCG's main providers as well as an overview of quality issues in Primary Care. Much of the information from these reports and detailed analysis of quality performance can be found in the CCG's Annual Report and other Quality Reports, the details here relate to issues specifically discussed at meetings.

3.3 Issues raised and discussed in relation to Royal Wolverhampton Trust throughout the year have included detailed consideration of a number of Serious Incidents and 'Never Events'. The committee has maintained an overview of the number and broad detail of the nature of incidents, including details of Never Events. This has been a particular concern for the committee, who escalated this issue to the Governing Body to seek further assurance, including correspondence between the Chair of the CCG and the trust. Detailed updates have also been given throughout the year on work at RWT to address issues associated with capacity in maternity services as part of a Black Country wide discussion about maternity provision. At the beginning of 2018, the committee has also sought further assurance around mortality figures at RWT, receiving details of work to understand potential data quality issues as well as on going reviews of mortality through both local and regional forums. Following triangulation with the Finance and Performance committee, discussions have also continued around the trust's performance on key national NHS Constitution measures on cancer performance and the potential impact on patient safety.

3.4 The committee has also been updated on quality monitoring at Black Country Partnership NHS Foundation Trust (BCPFT) on a monthly basis. This has broadly been on an exception basis and issues discussed have included details of Pressure injuries and discussions to undertake Root Cause Analysis into incidents that occur. Other queries discussed by the committee have included vacancy rates and performance rates for Improving Access to Psychological Therapies.

3.5 Following the CCG's approval as a fully delegated commissioner of Primary Care at the beginning of the year the committee, in support of the work of the Primary Care Commissioning Committee, has taken a more active role in the monitoring of the quality of provision in Primary Care. This has involved a monthly report which has detailed issues such as Friends and Family Test response rates and efforts to improve them, Infection Prevention Audits and liaison between the CCG and NHS England's arrangements for monitoring GP performance. The committee has noted work to support GP practices in addressing issues with information governance breaches as well as the collaborative approach taken to quality and contracting review with NHS England and City of Wolverhampton Council. In addition to the monthly reports, the committee has been kept specifically informed of changes to the arrangements for monitoring and improving inflection prevention controls, particularly in Primary Care. In May the committee was informed of enhanced standards and

considered further reports in September and December which gave greater detail on infection prevention across the health economy.

3.6 A number of the CCG's other providers have been discussed during the year, including a provider of 'Step Down' residential Care, which the committee has monitored throughout the year. Initially, the committee was advised that issues had been identified at the provider following an unannounced visit and then supported CCG management actions to support improvement, including placing restrictions on the CCG's contract with the provider. The committee received regular updates and were able to be assured that the actions taken by the provider were sufficient to improve quality and address the identified concerns. This resulted in the lifting of contractual sanctions towards the end of 2017. The committee were also advised of monitoring work with the provider of non-emergency patient transport services to ensure that they were able to meet the terms of their contract effectively.

3.7 Following concerns raised both through the CCG's own quality monitoring processes and external inspections, a significant body of work has been undertaken with the CCG's Urgent Care Centre provider Vocare to address significant concerns. The committee escalated their work on this issue to the Governing Body, which has been receiving their own assurance on a regular basis as work to support improvements continued. The committee has maintained an overview of this work, which has included contractual action and the establishment of a CCG led Improvement Board to monitor the implementation of a detailed action plan to address the issues in provision. Actions from the plan have included work to address data quality, recruitment and leadership and productivity and the committee has received assurance that the approach, challenge and targeted support provided has helped to support and sustain improvement. The committee also recognises that issues still remain and work to support Vocare will continue into the next financial year.

3.8 Other work the committee has conducted in relation to this theme has included regular reviews of quality assurance in specific sectors of the CCG's work including Continuing Healthcare and Medicines Management. The committee has also received regular reports on the CCG's work to assure quality in Care homes through the Quality Nurse Advisor team. This team works closely with colleagues in Adult Social Care at the City of Wolverhampton Council to ensure care homes are appropriately supported to provide appropriate standards of care. The Committee have been kept up to date with the CCG's Safer Provision and Care Excellence (SPACE) programme which is delivered in conjunction with Walsall CCG to support self improvement across the sector through effective sharing of best practice. The committee supported a business case to continue with this programme based on the success of the programme to date.

Risk Management and Assurance

3.9 As highlighted in last year's Annual report and the CCG's Annual Governance Statement, the CCG has reviewed its arrangements for risk management in response to recommendations from an Internal Audit review in 2016/17. As a result of this review, the committee's role in risk management has changed and it will now focus more on managing risks associated with its core areas of work. The Audit and Governance Committee is taking on the overall responsibility for ensuring that the CCG's risk management arrangements are appropriate and both committee's terms of reference will be amended to reflect this.

3.10 The committee continued to maintain an overview of the CCG's response to the 2016/17 Internal Audit report in the early part of 2017/18, receiving details of the

work to amend the Governing Body Assurance Framework to focus on the risk to the CCG's strategic priorities. Throughout the remainder of the year, the committee has led the other Governing Body Committees in reviewing risks identified in their areas of work. The committee has sought assurance that the risks identified have been effectively managed, considering details of controls and action plans to mitigate risks impacting on quality of care and patient safety across the system.

3.11 In response both to risks identified and the committee's previous work, assurance reports have been sought across specific areas of the CCG's work. This has included reports at regular intervals on both Business Continuity arrangements and broader Emergency Preparedness, Resilience Response. The committee has been assured that the CCG's plans in these crucial areas are sufficiently robust and will continue to monitor compliance as part of their regular reporting cycle. The committee has also sought to understand the CCG's broader approach to financial and performance management, considering reports from the Finance and Performance Committee. This has helped to ensure that both the assurance provided by the Finance and Performance Committee and the intelligence gathered through formal contract monitoring is effectively triangulated with this committee's work to address any quality concerns in a timely and effective manner.

3.12 Finally, the committee has sought to maintain its overall assurance through a broad overview of the CCG's quality function by understanding and endorsing the Qualtiy Team action plan at regular intervals throughout the year. This has helped to support the team in maintaining continuity of purpose whilst going through a period of staffing and leadership transition. The committee has noted the work undertaken by the team and, as highlighted above recognised that changes in the team will continue to build on the foundations laid previously. This included signing off the Quality Strategy in June 2017.

Monitoring the Group's arrangements for meeting statutory duties

3.13 As highlighted above, the committee has been given delegated responsibility within the CCG's Constitution to monitor performance against a number of statutory duties. The most significant of these are meeting the Public Sector Equality Duty, the duties in the National Health Service Act 2006 around public involvement in commissioning and information governance, including meeting responsibilities under the Freedom of Information Act. As these are specialist areas of work , the CCG purchases expert support from the Commissioning Support Unit (CSU) and teams from the CSU report to the committee on progress with their work.

3.14 The CCG has conducted a review of its Equality Strategy during the year following detailed consideration of the CCG's action plan response to the national NHS Equality Delivery System 2 (EDS2). This resulted in the committee agreeing four equality objectives in March 2018, two focussed on patients and two on the CCG's workforce. The CSU Equality and Diversity team have provided quarterly updates on progress with the action plan and committee has also received specific information about the CCG's work in relation to the Workplace Race Equality Standard.

3.15 Information Governance has remained high on the committee's agenda during the year, with regular updates from the Information Governance team at the CSU on work to ensure the CCG remained compliant with the national NHS Digital Information Governance Toolkit standard. This work was based around a workplan agreed by the committee in June which set out actions to ensure the CCG was able to evidence compliance across the standards in the Toolkit. The reports have set out that the CCG was on track to maintain its compliance levels at 89% and in March the

committee agreed to delegate final sign off of the Toolkit submission to the Senior Information Risk Owner and Information Governance lead. Details have also been provided throughout the year of the CCG's concurrent work to comply with changes in Data Protection legislation in response to the European Union General Data Protection Regulation (GDPR). The committee has reviewed the CCG's GDPR plan, and agreed appropriate action throughout the year, including the appointment of the Corporate Operations Manager as the CCG's Data Protection Officer.

3.16 The Committee has also maintained an overview of the CCG's compliance with its responsibilities under the Freedom of Information Act. This has been through quarterly reports that have given details of the numbers, source and nature of requests. Performance has remained high with 98% of requests responded to within the statutory framework. The committee has also agreed a procedure for dealing with requests to review how the CCG has managed requests when requesters have specific concerns about how it has been handled.

3.17 Work by the committee to review how the CCG's arrangements for patient and public involvement has continued to benefit from the work of the committees two patient representatives. Their role is crucial in ensuring that the committee's broader work to review the quality and safety of commissioned services takes account of patients views and experience. Other work undertaken in this area includes a review of the CCG's complaints policy in October 2017.

3.18 As well as the work undertaken to monitor those statutory duties which specifically relate to CCGs, the committee has also maintained a regular review of the CCG's arrangements for meeting Health and Safety duties as an employer. These reports have taken account of the CCG's position as a tenant in Wolverhampton Science Park and the committee have continued to be assured that arrangements in place are both proportionate and effective. The committee has also reviewed and agreed policies for areas including the management of Serious Incidents and complying with advice and guidance from the Nation Institute for Health and Care Excellence.

Safeguarding

3.19 As in previous years, the CCG's role in supporting and assuring arrangements to ensure that vulnerable children and adults are kept safe has been a key priority for the committee. Regular reports on both Adult and Children and Young People's safeguarding issues have been considered on a quarterly basis.

3.20 The committee has been advised that there has been a significant focus on ensuring arrangements for safeguarding are effective across Primary Care services, particularly as the CCG has taken on additional responsibility in this area as a delegated commissioner. The reports have highlighted work to support training programmes across Primary Care, including the use of innovative drama based training approaches as well as work to support day to day in work in General Practice on safeguarding matters.

3.21 Work to support children and young people's safeguarding issues has continued to focus on the multi-agency work across Wolverhampton, in which the CCG is an active participant. This has included reports on the outcome and recommendations from external inspections of the work across the health and care sector to safeguard children and young people from both Ofsted and the Care Quality Commission. The committee have also been informed of continuing efforts to ensure information sharing across agencies supports safeguarding, including a national initiative to

share data from urgent care settings when vulnerable children attend with appropriate professionals at the local authority.

3.22 The quarterly reports have also highlighted the ongoing work across the CCG to ensure that staff are appropriately trained to be aware of safeguarding issues that may arise. All staff within the CCG are required to undertake Level 1 awareness training and compliance rates have been reported throughout the year. The committee has also agreed the CCG's overall strategy for safeguarding, which aimed to integrate approaches to safeguarding for both vulnerable adults and children and young people.

3.23 Finally, for the first time the committee have begun to review the CCG's work to address the 'Prevent' agenda which aims to prevent vulnerable individuals at risk of extremism being drawn into terrorism. Details were given in June of work to ensure that the CCG's providers are complying effectively with the duty and that action plans were in place to address any issues raised as a result of self-assessments of their compliance. The committee will continue this work in the new year.

4. Conclusions

4.1 The committee believes that the evidence presented above demonstrates that it has effectively discharged its responsibilities on behalf of the Governing Body during the year. It has been another busy week, with a number of significant issues being discussed at the committee before being escalated to the Governing Body.

4.2 The committee recognises that its role is a crucial one to ensuring that the CCG is able to continue to keep quality at the heart and safety in the mind of the organisation. With that in mind, it has begun some work to review its terms of reference to ensure that its work and approach to managing this work remain effective. This will be the key focus as the committee moves forward into 2018/19, working to ensure that the CCG continues to commission services that are safe and effective for patients across Wolverhampton.

Appendix 1 – Attendance at Meetings

Appendix 2 – Quality and Safety Committee Duties (Extract from TOR)

The QSC is accountable to the governing body and its remit is to provide the governing body with assurance on the quality of services commissioned and promote a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience. It will deliver this remit in the context of the group's priorities, as they emerge and develop, and the risks associated with achieving them.

The duties of the QSC are driven by the priorities for the group and any associated risks or areas of quality improvement and operates a programme of business, agreed by the governing body, that is flexible to new and emerging priorities and risks.

The specific duties required of the QSC are:

- to monitor the group's delivery of the public sector equality duty (constitution 5.1.2(b);
- to receive reports from the group's representative on the Wolverhampton Health and Wellbeing Board with regard to development of the joint assessments and strategies and delivery of the latter (constitution 5.1.2(c)(ii));
- to monitor the group's compliance with its Statement of Principles relating to the duty secure public involvement (constitution 5.2.1);
- to monitor the group's delivery of the duty to promote awareness of and have regard to the NHS Constitution (constitution 5.2.2);
- to monitor the group's delivery of the duty to secure continuous improvement to the quality of services (constitution 5.2.4);
- to monitor the group's delivery of the duty to support NHS England with regard to improving the quality of primary medical services (constitution 5.2.5);
- to monitor the group's delivery of the duties to promote the involvement of patients, their carers and representatives and enable patients to make choices (constitution 5.2.7 and 5.2.8);
- approval of policies for risk management including assurance (Prime Financial Policy 15.2) , information governance (PFP 19.3), business continuity, emergency planning, security and complaints handling;
- to ensure that the group makes effective use of NHS England's Information Governance and any other relevant Toolkit(s) to assess its performance (PFP 19.3);
- endorsing action plans to address high scoring risks in the group's Risk Register (PFP 15.4).

It delivers these duties by developing and delivering annual work programmes giving appropriate focus to the following:

- seek assurance that the commissioning strategy for the clinical commissioning group fully reflects all elements of quality (patient experience, effectiveness and patient safety), keeping in mind that the strategy and response may need to adapt and change;

- provide assurance that commissioned services are being delivered in a high quality and safe manner, ensuring that quality sits at the heart of everything that the group does. This will include jointly commissioned services and supporting NHS England as regards the quality and safety of the secondary healthcare services that it commissions for the group's patients;
- provide assurance that the group is meeting its safeguarding responsibilities under Children's Act 2004, Vulnerable Groups Act 2006 and any subsequent relevant legislation;
- oversee and provide assurance that effective management of risk is in place to manage and address clinical governance issues including arrangements to proactively identify early warnings of failing systems;
- have oversight of the process and compliance issues concerning serious incidents requiring investigation (SIRI); be informed of all Never Events; inform the governing body of any escalation or sensitive issues in good time; ensure that the group and its healthcare providers are learning from SIRI and Never Events;
- ensure that there is a clear line of accountability for patient safety issues, including the reporting required by statute, regulations or locally agreed best practice;
- seek assurance on the performance of NHS organisations in terms of their interaction and/or regulation by the Care Quality Commission, Monitor and any other relevant regulatory bodies;
- receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans;
- ensure that a clear escalation process, including appropriate trigger points, is in place to enable appropriate engagement of external bodies on areas of concern;
- make recommendations as necessary, to the governing body on the remedial actions to be taken with regard to actual and evolving quality and safety issues and risks.

The vision for Public Health 2030

Longer, healthier lives

wolverhampton.gov.uk

CITY OF WOLVERHAMPTON COUNCIL

Our vision for the City of Wolverhampton in 2030

In 2030 the City of Wolverhampton will be a healthy, thriving city of opportunity where we…

CELEBRATE **ENTERPRISE, EDUCATION AND SKILLS**

HAVE A **CITY CENTRE** WE'RE PROUD OF

ARE SERIOUS ABOUT BOOSTING **HEALTH AND WELLBEING**

have a vibrant civic society that's focussed on the future, empowers local communities and is supported by local businesses and institutions

all play our part in creating a confident, buzzing city that's synonymous with **ambition, innovation** and **inclusion**

are committed to **sustainability** for future generations

have a **buoyant** and **resilient economy** that includes international manufacturing companies with local roots and a strong, vibrant and innovative business base

retain more of the value produced by our economy to **benefit the whole city**

have world class public services that **continually improve** and have collaboration and co-production at their heart

care and are **confident** about our **diversity**

make it **easy for businesses and visitors to access the city** and are well connected to the wider world through our infrastructure

Our vision for the health and wellbeing of our residents

By 2030,

our thriving City will:

- Help people live longer, healthier and more active lives
- Offer every child the best start in life
- Close the gap in healthy life expectancy both within the City and between Wolverhampton and the England average
- Ensure everyone is protected from harm, serious incidents and avoidable health threats

To achieve these, we are aspiring to be a 'health improving council' by:

- Maximising the positive impact of the health and wellbeing of our residents across everything the Council delivers and buys and the policies which are developed
- Driving a City-wide focus on tackling the wider determinants of health and wellbeing
- Providing leadership with partners to prevent ill health, especially targeting those in our City whose outcomes are worse
- Improving health outcomes through the genuine integration of health and social care
- Ensuring our statutory Public Health duties continue to be delivered

Foreword
Councillor Paul Sweet, Cabinet Member for Public Health and Wellbeing and John Denley, Director of Public Health

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.

The repositioning of Public Health from the NHS to local government in 2013[1] provided an unprecedented opportunity for councils to have an additional positive impact on these factors.

Over the past five years the City of Wolverhampton Council has made some very good progress.

However, since 2013 we have seen a reduction in life expectancy and a widening of the gap between the health of our wealthiest and most deprived communities.

Too many of our residents also live the last 20 years of their life in poor health. Austerity and Government cuts to service provision play a part in this. The challenge then, within this context of continuing financial pressures, is to tackle some of the most entrenched issues which impact on the health of the whole population.

We believe we need to rethink our approach to improving health. Last year provided the opportunity to do so when key local partners came together and agreed the vision, 'New Horizons - Our Vision for the City of Wolverhampton in 2030[2].' This provides a blueprint for a sustainable, successful future for the next generation of Wulfrunians.

The New Horizons vision sets a tone, outlining a firm commitment to working in partnership towards a common goal whilst recognising that we all need to play our part. It has created the opportunity to transform our approach to improving the health of residents at a population level.

It involves moving away from providing traditional behaviour change services to individuals and focusing more on making a difference to the factors that influence healthy life expectancy at a population level.

To prepare for our new approach, Public Health is going through a transformation. We are building a service designed to offer expert public health advice and support to all parts of the Council and external partners, especially the NHS.

We recognise that our approach is ambitious and significantly different, but evidence and need has demonstrated that we must act now.

The improvements we want to make will take time to achieve. That is why we have chosen a range of short to medium term public health indicators which, if we deliver well, and in partnership, will show that we are moving in the right direction together.

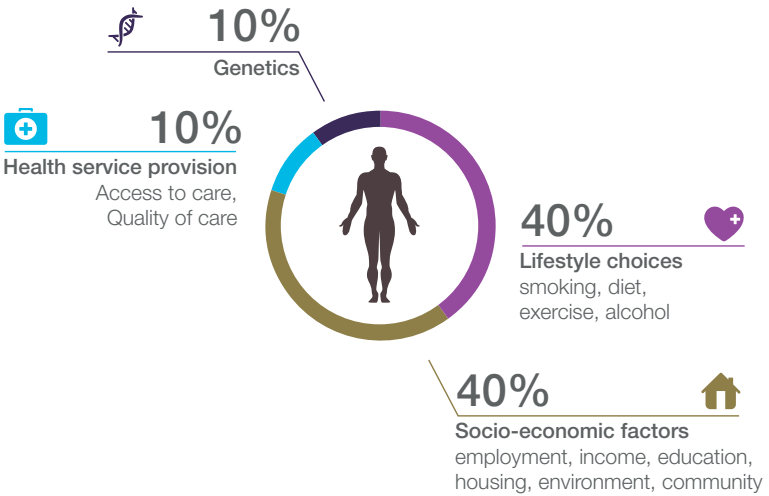
[1] Health and Social Care Act 2012. legislation.gov.uk/ukpga/2012/7/contents/enacted
[2] New Horizons - Our vision for the City of Wolverhampton in 2030. wolverhampton.gov.uk/vision2030

Photographs (left) Councillor Paul Sweet, Cabinet Member for Public Health and Wellbeing (right) John Denley, Director of Public Health

What factors influence our health?

The City of Wolverhampton is similar to most local authorities in that it faces common public health challenges. These include high obesity levels, smoking, alcohol misuse, rising levels of sexually transmitted infections, poor mental health and an ageing, unhealthy population.

There are a number of factors which strongly influence these challenges, making them very complex and difficult to tackle. The diagram below shows that these factors fall across four domains:



These factors are interrelated. For instance, residents who have a poor level of educational attainment are more likely to smoke.

Likewise, although harmful alcohol use is common across social groups, people with low incomes are more likely to be admitted to hospital with alcohol related conditions. Harmful alcohol use is exacerbated by poor mental health.

Evidence shows focusing on delivering services to individuals with unhealthy lifestyles, as we have done - such as stop smoking and weight management services - will not have a sustained positive impact on outcomes at a population level over the longer term.

We believe the scale and complexity of the challenges that Wolverhampton faces means that no single part of the system can make sustained progress on its own. This is why our approach will do more than support behaviour change and health services, but seek improvements in the broad factors which impact on people's lives. 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.

City health check - how do we compare?

1 in 3 children live in poverty

- 10% higher than the England average of 19.9%

22.5% of **adults smoke**

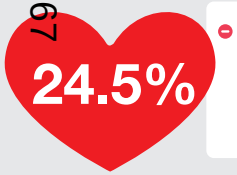
- rates improving
- higher than national average

Teenage pregnancies down from 56.8 per 1,000 in 2010 to 28 per 1,000 now

- rapid improvement since 2010
- higher average than England (17.7) and West Midlands (21.1)

School readiness rise from 44.2% in 2012/13 to 62.4% in 2017/18

- 18% improvement in last 4 years
- lower than national average of 69.3%



- 15.4% reducing trend and within the bottom 25% for performance across England

of those eligible received an NHS health check in the last 5 years

Alcohol admissions rise to 897 per 100,000

- rates stabilising
- upward trend
- higher than rate of 647 admissions nationally

Childhood obesity

26.7% of children at year 6 are obese

- upward trend is continuing to increase
- higher than England average of 20%

Adult obesity

28.5% of adults are classified as obese

- higher than England average of 24.4%

At 5.6 per 1,000 our **infant mortality rate** is 7th highest of our 16 nearest neighbours

- improved in recent years
- higher than England average of 3.9 per 1,000

4.1% claimed **unemployment benefits** in November 2017

- improved from a high of 8% at the beginning of 2013
- higher than England average of 2%

25.2% of carers get as much social contact as they desire and this is the 2nd worst compared to our neighbours

- decreasing trend
- lower than 35.5% average for England

35.6% of pupils achieved grade 9-5 English and Maths GCSE

- trend recently improved
- lower than 39.6% in England, and 39.8% for the West Midlands

What do we want to achieve?

We want all residents of the City of Wolverhampton to live longer and have a good quality of life.

Being in good health for as long as possible (known as having a 'healthy life expectancy') will impact on relationships with family and friends, the ability to fully participate in the community, and contribute to the local economy. Staying in good health into older age is also closely related to how much support and care a person needs and their use of services such as adult social care.

People living in Wolverhampton on average spend the last 20 years of their lives living with health related problems, the gap between national and Wolverhampton healthy life expectancy is 7 years for men and 4.6 years for women. Our vision is to increase life expectancy and healthy life expectancy considerably by 2030 to cut the gap between Wolverhampton and the national average. We will also close the gap in life expectancy between our richest and poorest wards.

Our targets for 2030

Male

- Healthy life expectancy (years)
- Life expectancy (years)

	2010	2015	2025	2030
Healthy life expectancy (years)	59.3	56.4	Continued improvement in line with our 2030 target	66
Life expectancy (years)	76.7	77.4		81
Life expectancy gap between richest and poorest wards (years)	13.7	11.3		8

Female

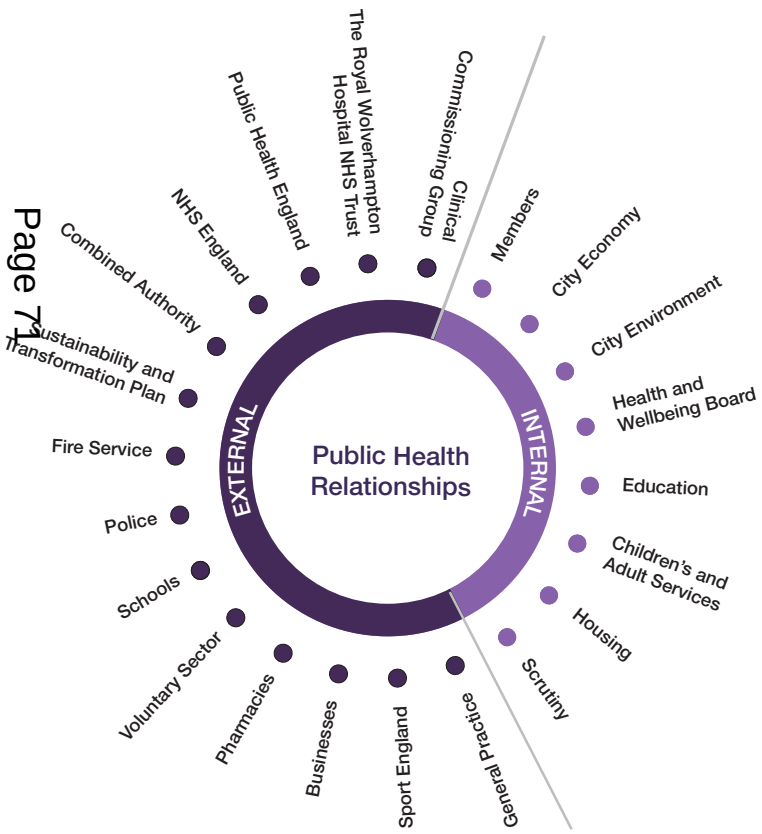
- Healthy life expectancy (years)
- Life expectancy (years)

	2010	2015	2025	2030
Healthy life expectancy (years)	58.3	59.5	Continued improvement in line with our 2030 target	69
Life expectancy (years)	80.3	81.4		84
Life expectancy gap between richest and poorest wards (years)	9.6	9.5		6

Improvements we will see along the way

Priority	Indicators		
Starting and Developing Well (0-24 age group)	• Increase the number of children ready to enter school • Tackle inequalities in educational attainment	• Continue to reduce levels of teenage pregnancy • Continue to tackle infant mortality	• Top performer in chlamydia detection
Healthy Life Expectancy	• Increase access to employment for people with mental health problems • Reduce substance misuse related reoffending	• Top performer in drug and alcohol recovery • Reduce the number of rough sleepers	• Increase physical activity • Reduce smoking prevalence • Top performer in uptake of NHS Health Checks
Healthy Ageing	• Increase wellbeing of carers	• Increase uptake of influenza vaccination	• Keeping people well in their community
System Leadership	• Embed Public Health and prevention in an integrated health and social care system	• Joint intelligence unit established for the City	• Working together across the whole public sector to improve health outcomes

Who will we work with and how?



We want to maximise the health impact of everything we do through the City of Wolverhampton Council and extend this to the actions of our partners.

This is why the Council's Public Health service is being transformed to provide the necessary expertise and technical advice to help make this happen.

The repositioning of the service will deliver our statutory public health responsibilities while also offering public health advice and support internally to embed the idea of improving health and reducing inequalities to all parts of the Council.

The Council and public sector partners will be working together as one to transform health outcomes across the City. Public Health will support and provide external advice to partners beyond the NHS and social care in taking a place based approach.

Key to extending the reach of public health will be a service equipped with the skills to engage, influence and persuade, with the ability to tell the story using data and evidence, whilst continually strengthening relationships.

Our role will be to facilitate a more co-ordinated strategic development of longer term planning for entrenched and future issues in health and social care; to encourage partners to think more broadly than current crises and; importantly, to make investments now for the long term health of the population of Wolverhampton.

You can get this information in large print, braille,
audio or in another language by calling 01902 551155

wolverhampton.gov.uk 01902 551155

WolverhamptonToday Wolverhampton_Today @WolvesCouncil

City of Wolverhampton Council, Civic Centre, St. Peter's Square,
Wolverhampton WV1 1SH

WCC 1644 03.18

Public Health Annual Report 2017

Health in City of Wolverhampton at a glance

wolverhampton.gov.uk

CITY OF WOLVERHAMPTON COUNCIL

Contents

Foreword
Councillor Paul Sweet

I would like to personally offer a warm welcome to John Denley who has recently joined the Council in his new post as Director of Public Health in City of Wolverhampton. I had the pleasure of working with the previous Director, Ros Jervis, and was proud of the achievements made since Public Health transitioned into the Council in 2013. However, looking forward, I am dedicated to tackling the entrenched challenges which the City still faces. Working towards the priorities identified under each work area in this annual report offers a real, tangible opportunity to support all residents to take health improving steps, regardless of individual circumstance. This report shows the variation in outcomes across the wards in City of Wolverhampton. This demonstrates the inequality in outcomes that persist in our City and a key challenge going forward will be to reduce these levels of inequality.

Councillor Sweet

Portfolio holder for Health and Wellbeing

Foreword
John Denley, Director of Public Health

Public health is about helping all people to stay healthy for longer and to protect against threats to health. Life expectancy and healthy life expectancy are the overarching outcomes we monitor to demonstrate how well we are doing. There are many factors which affect our health, from the environment, such as the air we breathe or the quality of the house we live in; our lifestyle, including the food we eat and exercise we take- plus smoking and alcohol; school attainment; our family's household income and stability of job, to health service delivery and possible infections.

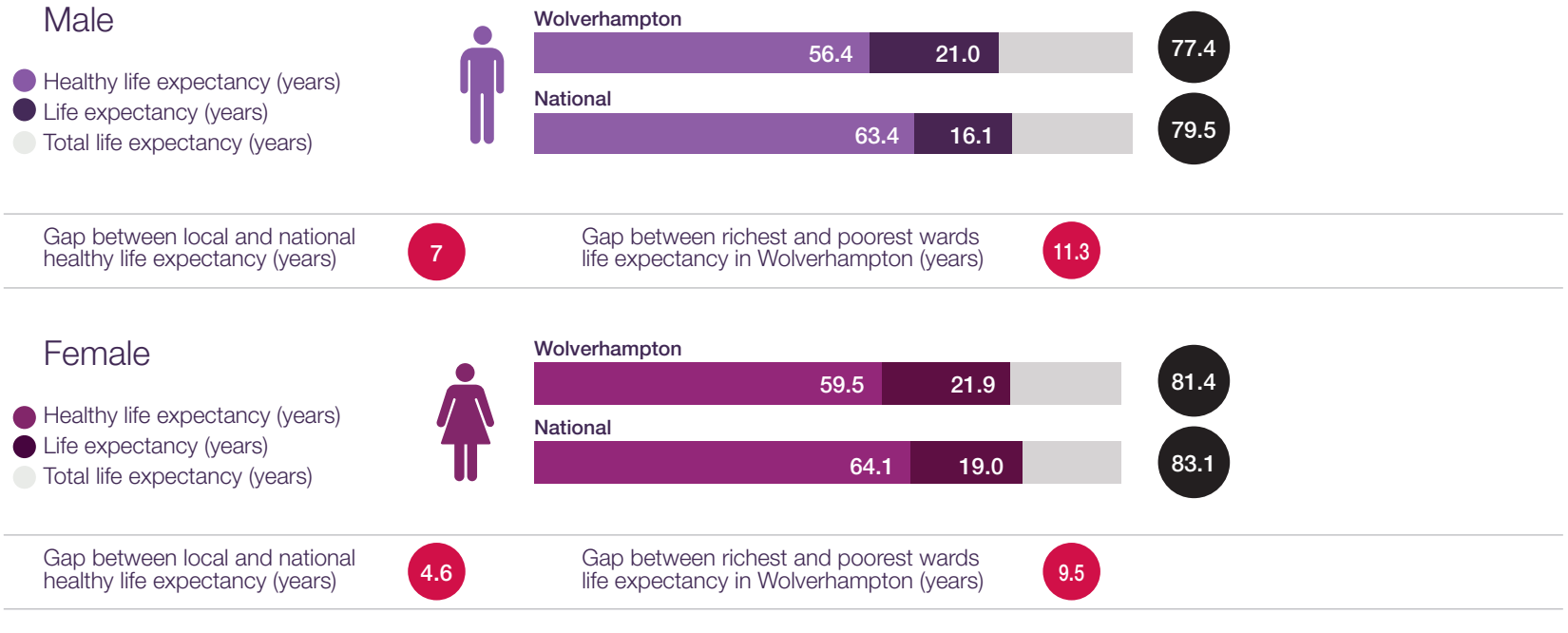
I am very happy to share my first annual report, which demonstrates the scale of the problems we face across the wards in the City and the focus of the 4 key workstreams in public health moving forward. In addition, this report lays out the planned improvements in the quality of the services we commission in public health over the next 12-18 months.

John Denley
Director of Public Health

The overarching measures of Public Health

A marker of overall public health is the life expectancy and healthy life expectancy within an area. Wolverhampton men and women live 7.0 and 4.6 years respectively in poorer health than the average in England. Equally, the gap between healthy life expectancy and life expectancy, the years lived in poorer health for Wolverhampton men is 21.0 years and for women, 21.9 years. It is these years lived in poorer health which usually lead to higher demand on our health and social care services in City of Wolverhampton.

Life expectancy and healthy life expectancy for men and women, Wolverhampton and England



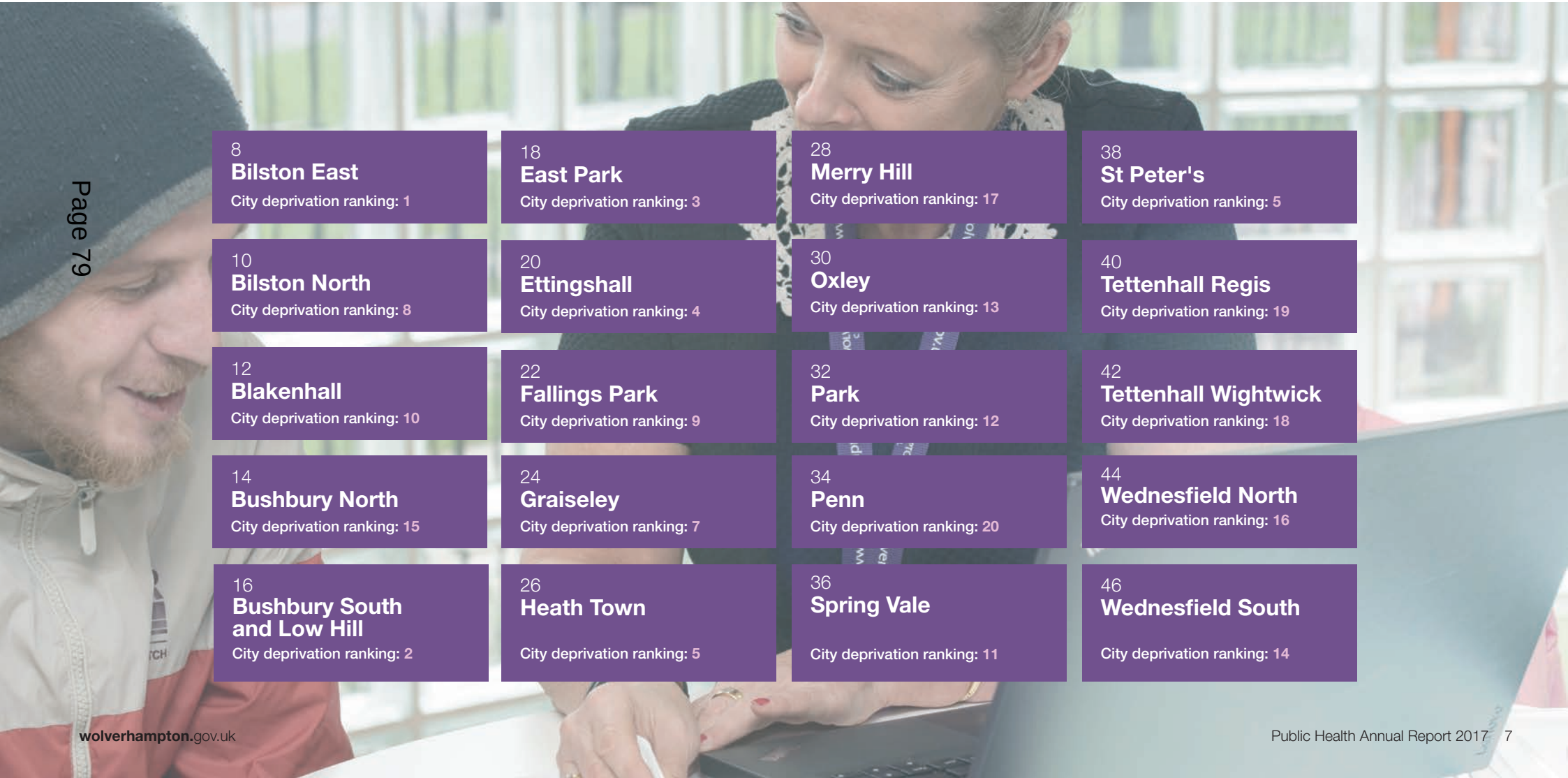
Workstreams

Priority	Indicators		
Starting and Developing Well (0-24 age group)	• Increase the number of children ready to enter school • Tackle inequalities in educational attainment	• Continue to reduce levels of teenage pregnancy • Continue to tackle infant mortality	• Top performer in chlamydia detection
Healthy Life Expectancy	• Increase access to employment for people with mental health problems • Reduce substance misuse related reoffending	• Top performer in drug and alcohol recovery • Reduce the number of rough sleepers	• Increase physical activity • Reduce smoking prevalence • Top performer in uptake of NHS Health Checks
Healthy Ageing	• Increase wellbeing of carers	• Increase uptake of influenza vaccination	• Keeping people well in their community
System Leadership	• Embed Public Health and prevention in an integrated health and social care system	• Joint intelligence unit established for the City	• Working together across the whole public sector to improve health outcomes

The City of Wolverhampton public health team in has been reorganised to meet the challenges public health faces over the coming years. This reorganisation has led to the formulation of 4 key workstreams (above). Each of these workstreams will be led by a consultant in public health.

The following pages show the key indicators across each of these work areas across the wards of Wolverhampton. The systems leadership priority will work to underpin this work across the whole of Public Health.

Your ward at a glance



8
Bilston East
City deprivation ranking: 1

10
Bilston North
City deprivation ranking: 8

12
Blakenhall
City deprivation ranking: 10

14
Bushbury North
City deprivation ranking: 15

16
Bushbury South and Low Hill
City deprivation ranking: 2

18
East Park
City deprivation ranking: 3

20
Ettingshall
City deprivation ranking: 4

22
Fallings Park
City deprivation ranking: 9

24
Graiseley
City deprivation ranking: 7

26
Heath Town
City deprivation ranking: 5

28
Merry Hill
City deprivation ranking: 17

30
Oxley
City deprivation ranking: 13

32
Park
City deprivation ranking: 12

34
Penn
City deprivation ranking: 20

36
Spring Vale
City deprivation ranking: 11

38
St Peter's
City deprivation ranking: 5

40
Tettenhall Regis
City deprivation ranking: 19

42
Tettenhall Wightwick
City deprivation ranking: 18

44
Wednesfield North
City deprivation ranking: 16

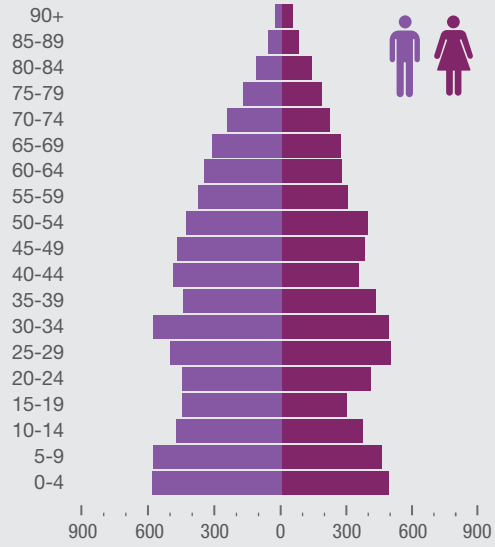
46
Wednesfield South
City deprivation ranking: 14

Your ward at a glance:

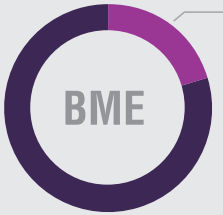
Bilston East

Wards

Total population: **14,542**



Key Demographic Facts



20.5%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
51.2
(City average: 33.2)

Key features from social marketing tool, MOSAIC

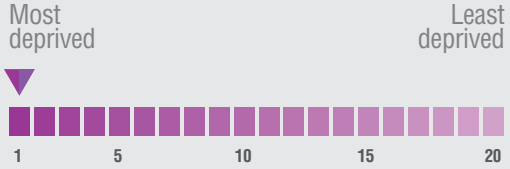
experian

Key feature 1
Elderly

Key feature 2
Living alone

Key feature 3
Low income

City deprivation ranking: 1



0-24 age group

Starting and Developing Well

24.2%
of pupils achieved grade 9-5 English and Maths GCSE

This is worse than the city average

35.9
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

117.7
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity

30.4%
of children at **year 6 are obese**

This is worse than the city average

25-64 age group

Healthy Life Expectancy

4.8%
claimed **unemployment benefits** in November 2017

This is close to the city average

13.4%
of houses with one or more **category 1 hazards** identified

This is better than the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Obese and Average Wellbeing**
3. **Overweights**

65+ age group

Healthy Ageing

10.2%
of people **providing unpaid care** are in **bad or very bad health**

This is worse than the city average

28.5%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

1,660
people per 100k are living in **residential or nursing care** permanently

This is close to the city average

14.6%
of people aged 65 years and over have **below average or very low wellbeing**

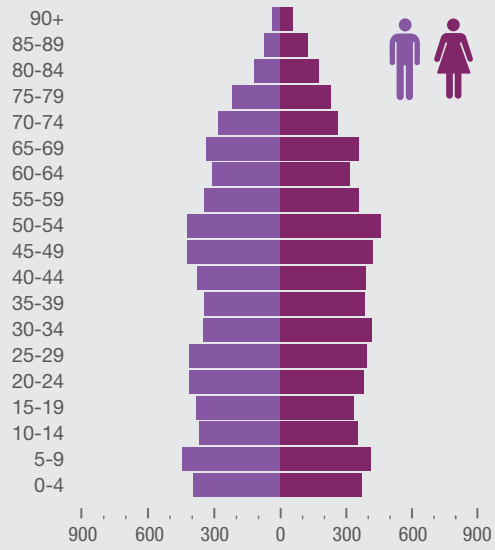
This is worse than the city average

Your ward at a glance:

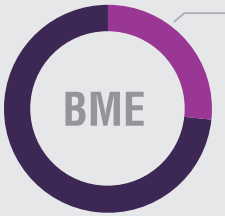
Bilston North

Wards

Total population: **12,297**



Key Demographic Facts



26.8%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
36.5
(City average: 33.2)

Key features from social marketing tool, MOSAIC

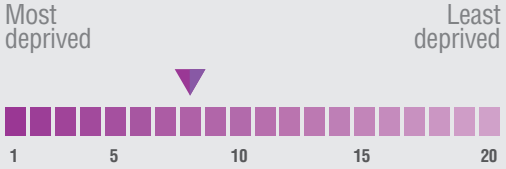
experian

Key feature 1
Families with children

Key feature 2
Aged 25 to 40

Key feature 3
Limited resources

City deprivation ranking: 8



0-24 age group

Starting and Developing Well

31.9% of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

40.4 **teenage pregnancies** per 1,000 under-18 yr olds

This is worse than the city average

96.9 children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity

29.3% of children at **year 6 are obese**

This is worse than the city average

25-64 age group

Healthy Life Expectancy

3.7% claimed **unemployment benefits** in November 2017

This is close to the city average

14.9% of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1. Healthy Weight Poor Lifestyle
2. Overweights
3. Obese and Average Wellbeing

65+ age group

Healthy Ageing

8.2% of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

20.4% of people over 65 years old have an **illness that limits their daily activities**

This is better than the city average

1,596 people per 100k are living in **residential or nursing care** permanently

This is better than the city average

8.1% of people aged 65 years and over have **below average or very low wellbeing**

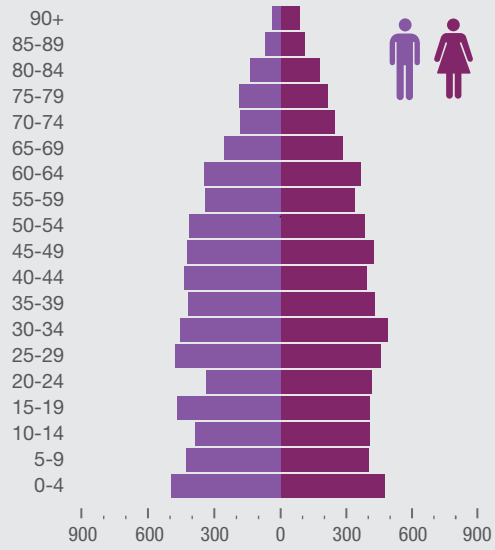
This is close to the city average

Your ward at a glance:

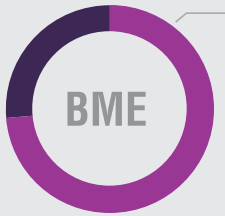
Blakenhall

Wards

Total population: **12,790**



Key Demographic Facts



73.7%
of the population is
Black or Minority Ethnic
(City average: 32%)

More deprived

Deprivation score:
32.9
(City average: 33.2)

Less deprived

Key features from social marketing tool, MOSAIC

experian

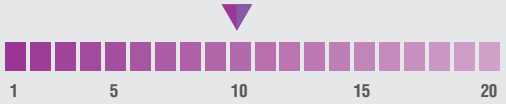
Key feature 1
Settled extended families

Key feature 2
City suburbs

Key feature 3
Multicultural

City deprivation ranking: **10**

Most deprived — Least deprived



0-24 age group

Starting and Developing Well

42.1%
of pupils achieved grade 9-5 English and Maths GCSE

This is better than the city average

26.3
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

99.6
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity
28.1%
of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

3.9%
claimed **unemployment benefits** in November 2017

This is close to the city average

20.9%
of houses with one or more **category 1 hazards** identified

This is worse than the city average

Predominant clusters from Healthy Lifestyle survey

1 **Healthy Weight Poor Lifestyle**

2 **Overweights**

3 **Healthy Eaters**

65+ age group

Healthy Ageing

8.3%
of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

21.4%
of people over 65 years old have an **illness that limits their daily activities**

This is better than the city average

8,622
people per 100k are living in **residential or nursing care** permanently

This is worse than the city average

12.8%
of people aged 65 years and over have **below average or very low wellbeing**

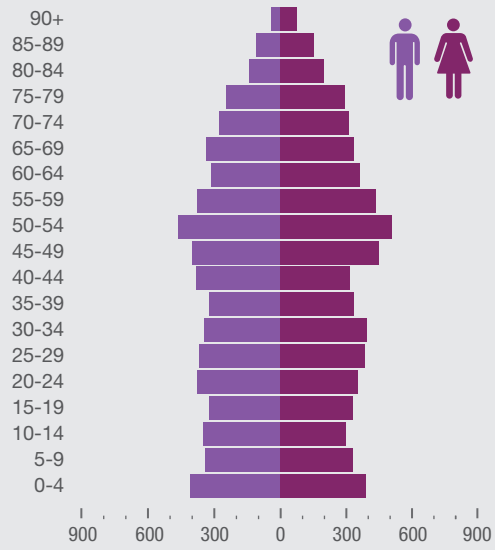
This is close to the city average

Your ward at a glance:

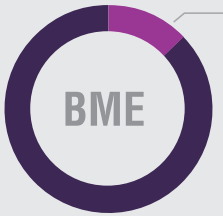
Bushbury North

Wards

Total population: **11,971**



Key Demographic Facts



12.8%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
27.8
(City average: 33.2)

Key features from social marketing tool, MOSAIC

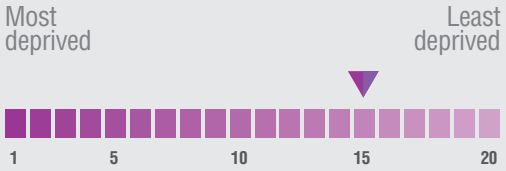
experian

Key feature 1
Younger households

Key feature 2
Full-time employment

Key feature 3
Private suburbs

City deprivation ranking: 15



0-24 age group

Starting and Developing Well

28.1%
of pupils achieved grade 9-5 English and Maths GCSE

This is worse than the city average

28.3
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

105.6
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity

25.9%
of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

3.3%
claimed **unemployment benefits** in November 2017

This is close to the city average

14.5%
of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Used to Smoke**
3. **Healthy Eaters**

65+ age group

Healthy Ageing

7.8%
of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

22.6%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

1,817
people per 100k are living in **residential or nursing care** permanently

This is close to the city average

8.3%
of people aged 65 years and over have **below average or very low wellbeing**

This is close to the city average

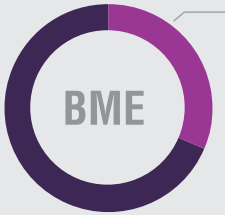
Your ward at a glance:

Bushbury South and Low Hill

Wards

Total population: **15,853**

Key Demographic Facts



31.6%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
47.8
(City average: 33.2)

Key features from social marketing tool, MOSAIC

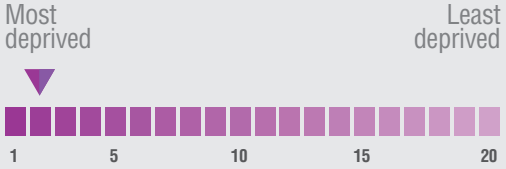
experian

Key feature 1
Families with children

Key feature 2
Aged 25 to 40

Key feature 3
Limited resources

City deprivation ranking: 2



0-24 age group

Starting and Developing Well

24.6%
of pupils achieved grade 9-5 English and Maths GCSE

This is worse than the city average

49.0
teenage pregnancies per 1,000 under-18 yr olds

This is worse than the city average

190.2
children per 10,000 are in **Local Authority Care**

This is worse than the city average

Childhood obesity
28.1%
of children at **year 6 are obese**

This is worse than the city average

25-64 age group

Healthy Life Expectancy

5.6%
claimed **unemployment benefits** in November 2017

This is worse than the city average

17.3%
of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Overweights**
3. **Obese and Average Wellbeing**

65+ age group

Healthy Ageing

9.0%
of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

28.0%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

3,945
people per 100k are living in **residential or nursing care** permanently

This is worse than the city average

21.6%
of people aged 65 years and over have **below average or very low wellbeing**

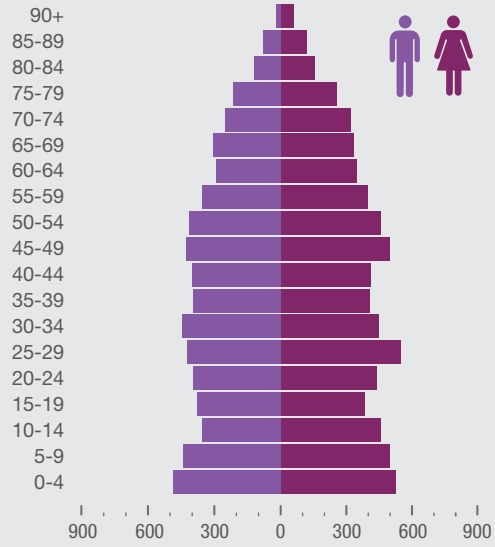
This is worse than the city average

Your ward at a glance:

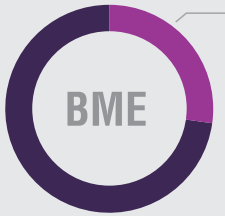
East Park

Wards

Total population: **12,892**



Key Demographic Facts



27.4%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
44.7
(City average: 33.2)

Key features from social marketing tool, MOSAIC

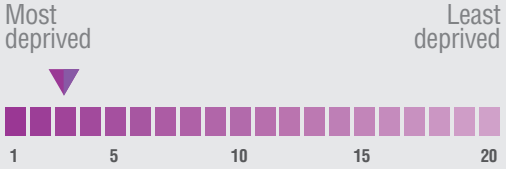
experian

Key feature 1
Families with children

Key feature 2
Aged 25 to 40

Key feature 3
Limited resources

City deprivation ranking: 3



0-24 age group

Starting and Developing Well

25.4% of pupils achieved grade 9-5 English and Maths GCSE

This is worse than the city average

55.5 **teenage pregnancies** per 1,000 under-18 yr olds

This is worse than the city average

197.9 children per 10,000 are in **Local Authority Care**

This is worse than the city average

Childhood obesity

27.2% of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

6.1% claimed **unemployment benefits** in November 2017

This is worse than the city average

14.0% of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Obese and Average Wellbeing**
3. **Used to Smoke**

65+ age group

Healthy Ageing

10.3% of people **providing unpaid care** are in **bad or very bad health**

This is worse than the city average

28.9% of people over 65 years old have an **illness that limits their daily activities**

This is worse than the city average

1,646 people per 100k are living in **residential or nursing care** permanently

This is close to the city average

10.9% of people aged 65 years and over have **below average or very low wellbeing**

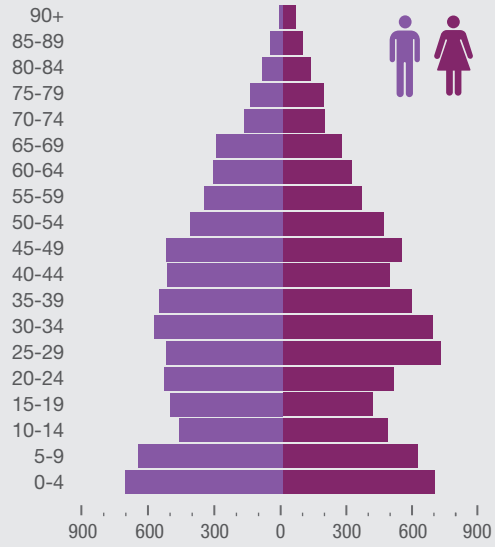
This is close to the city average

Your ward at a glance:

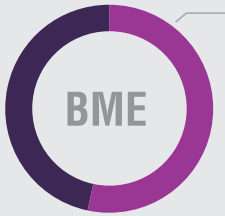
Ettingshall

Wards

Total population: **15,245**



Key Demographic Facts



53.5%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
43.8
(City average: 33.2)

Key features from social marketing tool, MOSAIC

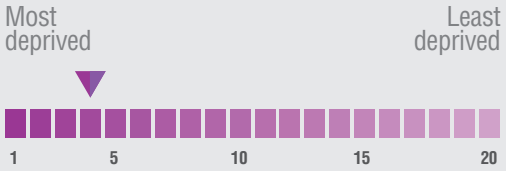
experian

Key feature 1
Private renters

Key feature 2
Low length of residence

Key feature 3
Low cost housing

City deprivation ranking: 4



0-24 age group

Starting and Developing Well

29.5%
of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

34.2
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

189.6
children per 10,000 are in **Local Authority Care**

This is worse than the city average

Childhood obesity
25.9%
of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

5%
claimed **unemployment benefits** in November 2017

This is close to the city average

17.7%
of houses with one or more **category 1 hazards** identified

This is worse than the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Overweights**
3. **Used to Smoke**

65+ age group

Healthy Ageing

7.4%
of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

18.5%
of people over 65 years old have an **illness that limits their daily activities**

This is better than the city average

2,060
people per 100k are living in **residential or nursing care** permanently

This is close to the city average

12.7%
of people aged 65 years and over have **below average or very low wellbeing**

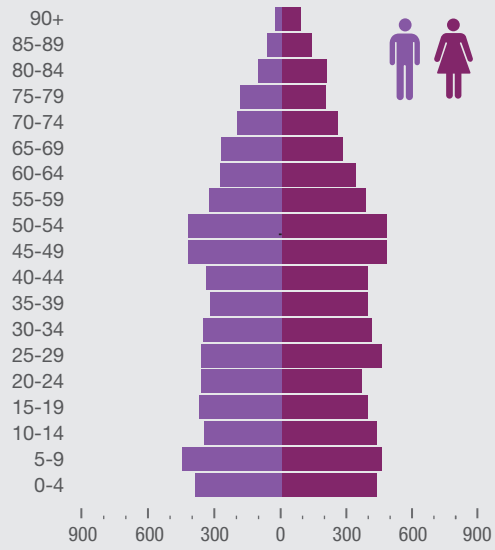
This is close to the city average

Your ward at a glance:

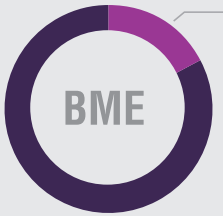
Fallings Park

Wards

Total population: **12,199**



Key Demographic Facts



17.4%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
34.6
(City average: 33.2)

Key features from social marketing tool, MOSAIC

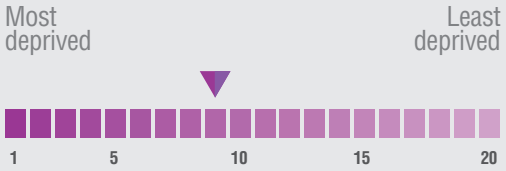
experian

Key feature 1
Younger households

Key feature 2
Full-time employment

Key feature 3
Private suburbs

City deprivation ranking: 9



0-24 age group

Starting and Developing Well

27.5% of pupils achieved grade 9-5 English and Maths GCSE

This is worse than the city average

37.5 **teenage pregnancies** per 1,000 under-18 yr olds

This is worse than the city average

134.5 children per 10,000 are in **Local Authority Care**

This is worse than the city average

Childhood obesity

28.8% of children at **year 6 are obese**

This is worse than the city average

25-64 age group

Healthy Life Expectancy

4.3% claimed **unemployment benefits** in November 2017

This is close to the city average

17.2% of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1 **Overweights**

2 **Healthy Weight Poor Lifestyle**

3 **Obese and Average Wellbeing**

65+ age group

Healthy Ageing

7.1% of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

30.3% of people over 65 years old have an **illness that limits their daily activities**

This is worse than the city average

2,180 people per 100k are living in **residential or nursing care** permanently

This is close to the city average

7.2% of people aged 65 years and over have **below average or very low wellbeing**

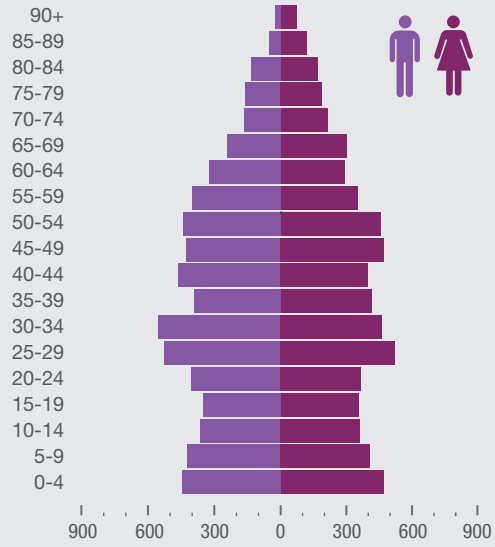
This is better than the city average

Your ward at a glance:

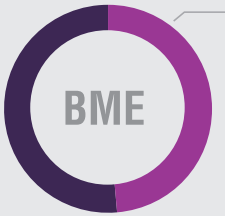
Graiseley

Wards

Total population: **12,607**



Key Demographic Facts



48.8%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
37.1
(City average: 33.2)

Key features from social marketing tool, MOSAIC

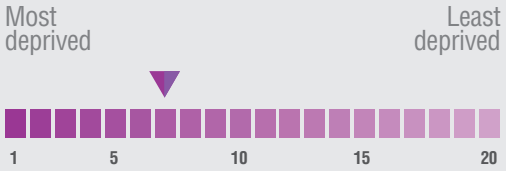
experian

Key feature 1
Private renters

Key feature 2
Low length of residence

Key feature 3
Low cost housing

City deprivation ranking: 7



0-24 age group

Starting and Developing Well

38.9%
of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

35.9
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

139.0
children per 10,000 are in **Local Authority Care**

This is worse than the city average

Childhood obesity

25.5%
of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

5.1%
claimed **unemployment benefits** in November 2017

This is worse than the city average

20.9%
of houses with one or more **category 1 hazards** identified

This is worse than the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Overweights**
3. **Healthy Eaters**

65+ age group

Healthy Ageing

7.2%
of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

22.3%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

4,864
people per 100k are living in **residential or nursing care** permanently

This is worse than the city average

10.5%
of people aged 65 years and over have **below average or very low wellbeing**

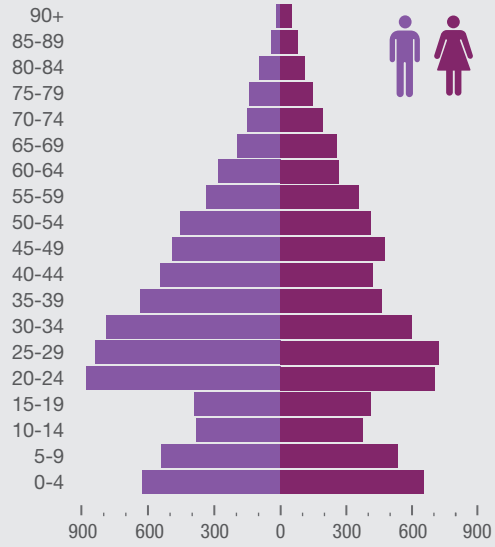
This is close to the city average

Your ward at a glance:

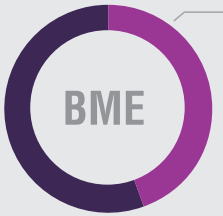
Heath Town

Wards

Total population: **15,090**



Key Demographic Facts



44.5%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
42.6
(City average: 33.2)

Key features from social marketing tool, MOSAIC

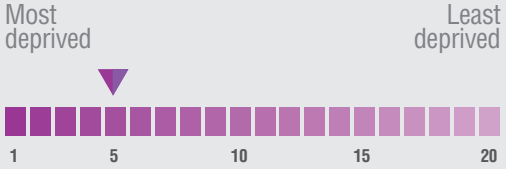
experian

Key feature 1
Families with children

Key feature 2
Aged 25 to 40

Key feature 3
Limited resources

City deprivation ranking: 5



0-24 age group

Starting and Developing Well

34.2%
of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

42.3
teenage pregnancies per 1,000 under-18 yr olds

This is worse than the city average

119.5
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity
27.1%
of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

5.5%
claimed **unemployment benefits** in November 2017

This is worse than the city average

13.2%
of houses with one or more **category 1 hazards** identified

This is better than the city average

Predominant clusters from Healthy Lifestyle survey

1. Healthy Weight Poor Lifestyle
2. Obese and Average Wellbeing
3. Overweights

65+ age group

Healthy Ageing

9.3%
of people **providing unpaid care** are in **bad or very bad health**

This is worse than the city average

24.3%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

4,304
people per 100k are living in **residential or nursing care** permanently

This is worse than the city average

10.6%
of people aged 65 years and over have **below average or very low wellbeing**

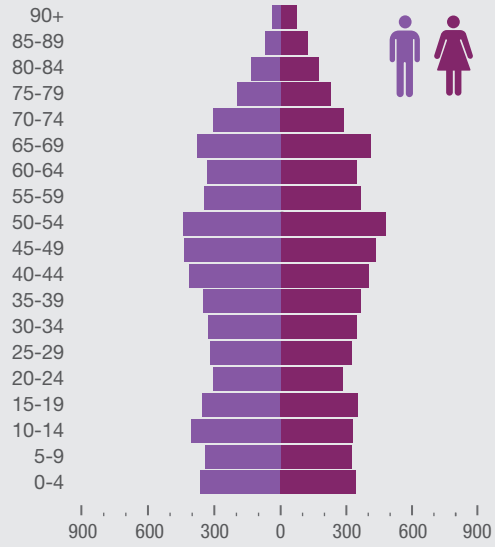
This is close to the city average

Your ward at a glance:

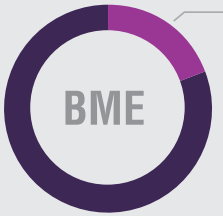
Merry Hill

Wards

Total population: **11,931**



Key Demographic Facts



19.4%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
21.1
(City average: 33.2)

Key features from social marketing tool, MOSAIC

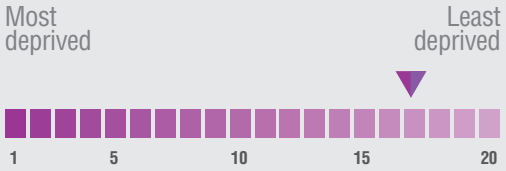
experian

Key feature 1
Elderly singles and couples

Key feature 2
Homeowners

Key feature 3
Comfortable homes

City deprivation ranking: 17



0-24 age group

Starting and Developing Well

42.3%
of pupils achieved grade 9-5 English and Maths GCSE

This is better than the city average

22.9
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

62.8
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity

21.6%
of children at **year 6 are obese**

This is better than the city average

25-64 age group

Healthy Life Expectancy

3.0%
claimed **unemployment benefits** in November 2017

This is better than the city average

15.4%
of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Overweights**
3. **Drinkers and Smokers**

65+ age group

Healthy Ageing

7.1%
of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

34.1%
of people over 65 years old have an **illness that limits their daily activities**

This is worse than the city average

143
people per 100k are living in **residential or nursing care** permanently

This is better than the city average

20.0%
of people aged 65 years and over have **below average or very low wellbeing**

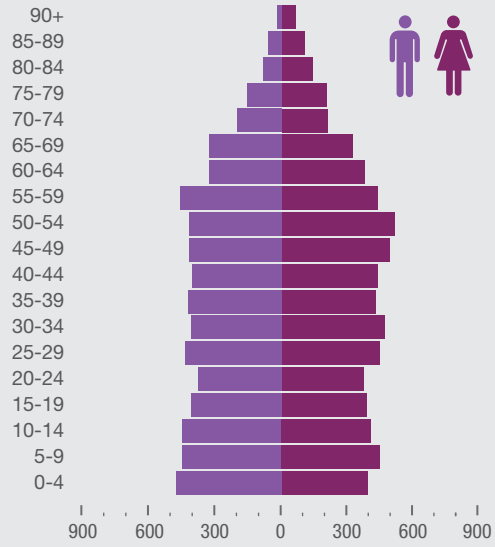
This is worse than the city average

Your ward at a glance:

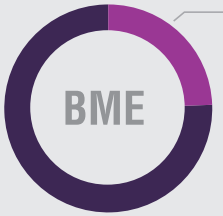
Oxley

Wards

Total population: **12,823**



Key Demographic Facts



24.5%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
29.7
(City average: 33.2)

Key features from social marketing tool, MOSAIC

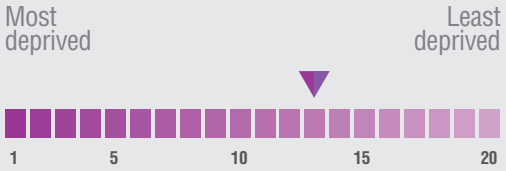
experian

Key feature 1
Families with children

Key feature 2
Aged 25 to 40

Key feature 3
Limited resources

City deprivation ranking: 13



0-24 age group

Starting and Developing Well

31.5%
of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

27.9
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

81.5
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity

26.1%
of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

3.9%
claimed **unemployment benefits** in November 2017

This is close to the city average

12.3%
of houses with one or more **category 1 hazards** identified

This is better than the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Overweights**
3. **Healthy Eaters**

65+ age group

Healthy Ageing

7.3%
of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

25.2%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

1,673
people per 100k are living in **residential or nursing care** permanently

This is close to the city average

9.4%
of people aged 65 years and over have **below average or very low wellbeing**

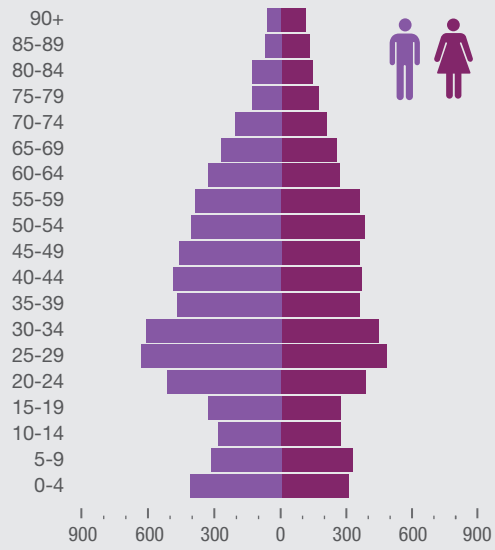
This is close to the city average

Your ward at a glance:

Park

Wards

Total population: **12,480**



Key Demographic Facts

42.7%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
30.8
(City average: 33.2)

Key features from social marketing tool, MOSAIC

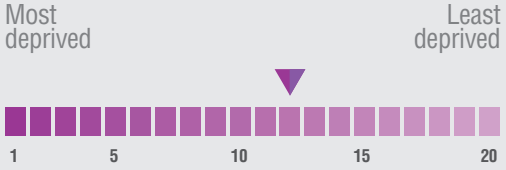
experian

Key feature 1
Aged 18-35

Key feature 2
Private renting

Key feature 3
Singles and sharers

City deprivation ranking: 12



0-24 age group

Starting and Developing Well

44.7%
of pupils achieved grade 9-5 English and Maths GCSE

This is better than the city average

34.9
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

98.0
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity
22.5%
of children at **year 6 are obese**

This is better than the city average

25-64 age group

Healthy Life Expectancy

5.0%
claimed **unemployment benefits** in November 2017

This is close to the city average

21.9%
of houses with one or more **category 1 hazards** identified

This is worse than the city average

Predominant clusters from Healthy Lifestyle survey

1 **Vigorously Active**

2 **Healthy Weight Poor Lifestyle**

3 **Drinkers and Smokers**

65+ age group

Healthy Ageing

6.5%
of people **providing unpaid care** are in **bad or very bad health**

This is better than the city average

18.6%
of people over 65 years old have an **illness that limits their daily activities**

This is better than the city average

9,670
people per 100k are living in **residential or nursing care** permanently

This is worse than the city average

14.6%
of people aged 65 years and over have **below average or very low wellbeing**

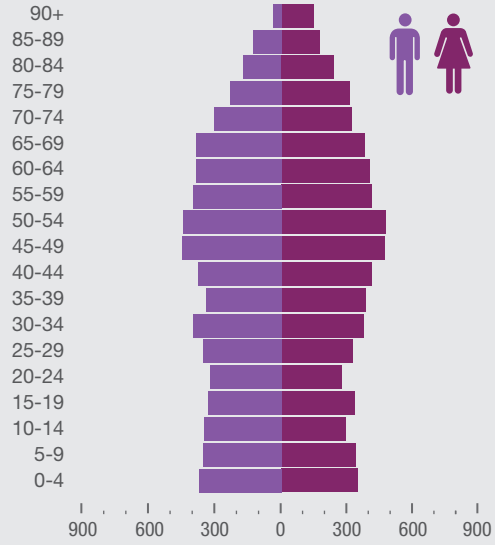
This is worse than the city average

Your ward at a glance:

Penn

Wards

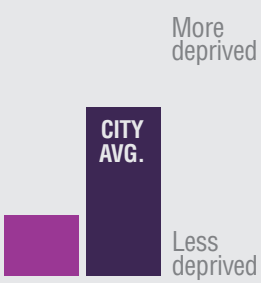
Total population: **12,508**



Key Demographic Facts

33.0%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
12.0
(City average: 33.2)



Key features from social marketing tool, MOSAIC

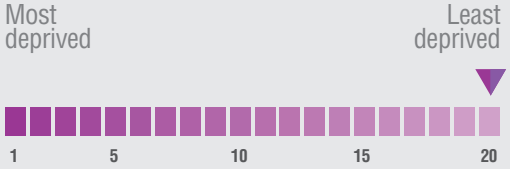
experian

Key feature 1
Older families

Key feature 2
Some adult children at home

Key feature 3
Suburban mid-range homes

City deprivation ranking: **20**



0-24 age group

Starting and Developing Well

47.2%
of pupils achieved grade 9-5 English and Maths GCSE

This is better than the city average

10.1
teenage pregnancies per 1,000 under-18 yr olds

This is better than the city average

<25
children per 10,000 are in **Local Authority Care**

This is better than the city average

Childhood obesity
20.5%
of children at **year 6 are obese**

This is better than the city average

25-64 age group

Healthy Life Expectancy

1.7%
claimed **unemployment benefits** in November 2017

This is better than the city average

17.7%
of houses with one or more **category 1 hazards** identified

This is worse than the city average

Predominant clusters from Healthy Lifestyle survey

1 Healthy Eaters

2 Healthy Weight Poor Lifestyle

3 Overweights

65+ age group

Healthy Ageing

4.6%
of people **providing unpaid care** are in **bad or very bad health**

This is better than the city average

21.5%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

3,851
people per 100k are living in **residential or nursing care** permanently

This is close to the city average

5.9%
of people aged 65 years and over have **below average or very low wellbeing**

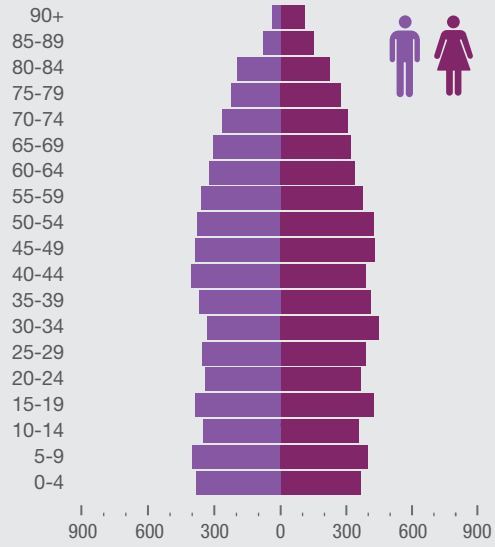
This is better than the city average

Your ward at a glance:

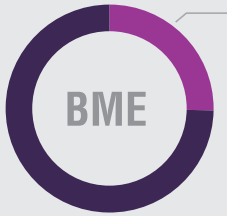
Spring Vale

Wards

Total population: **12,054**



Key Demographic Facts



25.4%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
31.1
(City average: 33.2)

Key features from social marketing tool, MOSAIC

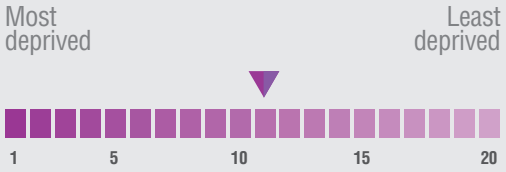
experian

Key feature 1
Families with children

Key feature 2
Aged 25 to 40

Key feature 3
Limited resources

City deprivation ranking: 11



0-24 age group

Starting and Developing Well

29.4%
of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

18.5
teenage pregnancies per 1,000 under-18 yr olds

This is better than the city average

56.3
children per 10,000 are in **Local Authority Care**

This is better than the city average

Childhood obesity
25.7%
of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

3.3%
claimed **unemployment benefits** in November 2017

This is close to the city average

14.6%
of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Obese and Average Wellbeing**
3. **Overweights**

65+ age group

Healthy Ageing

9.1%
of people **providing unpaid care** are in **bad or very bad health**

This is worse than the city average

27.5%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

3,396
people per 100k are living in **residential or nursing care** permanently

This is close to the city average

4.4%
of people aged 65 years and over have **below average or very low wellbeing**

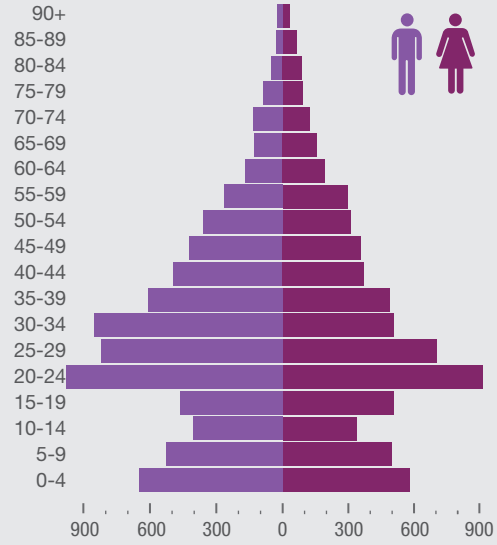
This is better than the city average

Your ward at a glance:

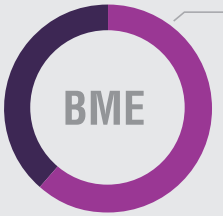
St Peter's

Wards

Total population: **14,044**



Key Demographic Facts



61.6%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
42.6
(City average: 33.2)

More deprived

Less deprived

Key features from social marketing tool, MOSAIC

experian

Key feature 1
Private renters

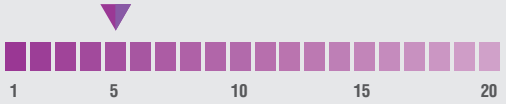
Key feature 2
Low length of residence

Key feature 3
Low cost housing

City deprivation ranking: 5

Most deprived

Least deprived



0-24 age group

Starting and Developing Well

29.7%
of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

33.7
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

117.7
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity

29.9%
of children at **year 6 are obese**

This is worse than the city average

25-64 age group

Healthy Life Expectancy

6.2%
claimed **unemployment benefits** in November 2017

This is worse than the city average

17.5%
of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Weight Poor Lifestyle**
2. **Overweights**
3. **Used to Smoke**

65+ age group

Healthy Ageing

11.0%
of people **providing unpaid care** are in **bad or very bad health**

This is worse than the city average

17.4%
of people over 65 years old have an **illness that limits their daily activities**

This is better than the city average

154
people per 100k are living in **residential or nursing care** permanently

This is better than the city average

15.6%
of people aged 65 years and over have **below average or very low wellbeing**

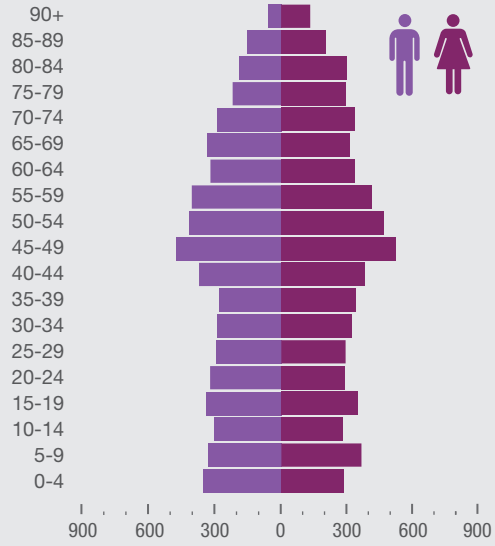
This is worse than the city average

Your ward at a glance:

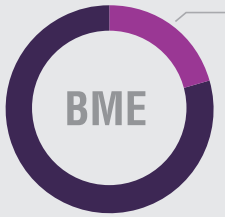
Tettenhall Regis

Wards

Total population: **11,820**



Key Demographic Facts



22.2%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
13.6
(City average: 33.2)

Key features from social marketing tool, MOSAIC

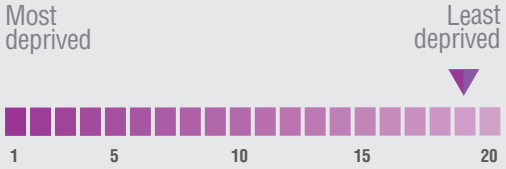
experian

Key feature 1
Younger households

Key feature 2
Full-time employment

Key feature 3
Private suburbs

City deprivation ranking: 19



0-24 age group

Starting and Developing Well

47.3%
of pupils achieved grade 9-5 English and Maths GCSE

This is better than the city average

7.2
teenage pregnancies per 1,000 under-18 yr olds

This is better than the city average

39.2
children per 10,000 are in **Local Authority Care**

This is better than the city average

Childhood obesity

23.5%
of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

1.8%
claimed **unemployment benefits** in November 2017

This is better than the city average

15.8%
of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1. **Healthy Eaters**
2. **Healthy Weight Poor Lifestyle**
3. **Drinkers and Smokers**

65+ age group

Healthy Ageing

5.7%
of people **providing unpaid care** are in **bad or very bad health**

This is better than the city average

28.4%
of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

3,039
people per 100k are living in **residential or nursing care** permanently

This is close to the city average

4.9%
of people aged 65 years and over have **below average or very low wellbeing**

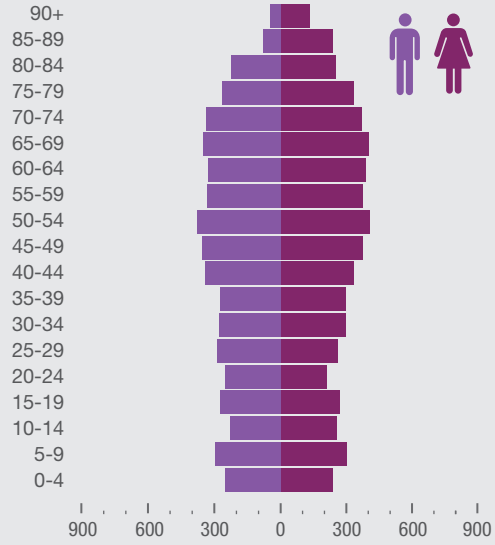
This is better than the city average

Your ward at a glance:

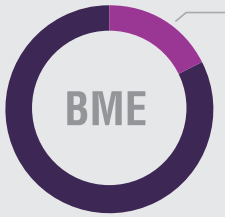
Tettenhall Wightwick

Wards

Total population: **10,946**



Key Demographic Facts



17.6%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
14.2
(City average: 33.2)

Key features from social marketing tool, MOSAIC

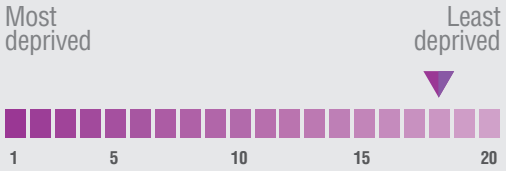
experian

Key feature 1
High value detached homes

Key feature 2
Married couples

Key feature 3
Managerial and senior positions

City deprivation ranking: 18



0-24 age group

Starting and Developing Well

38.7% of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

12.3 **teenage pregnancies** per 1,000 under-18 yr olds

This is better than the city average

<25 children per 10,000 are in **Local Authority Care**

This is better than the city average

Childhood obesity

17.7% of children at **year 6 are obese**

This is better than the city average

25-64 age group

Healthy Life Expectancy

1.9% claimed **unemployment benefits** in November 2017

This is better than the city average

11.7% of houses with one or more **category 1 hazards** identified

This is better than the city average

Predominant clusters from Healthy Lifestyle survey

1. Healthy Eaters
2. Healthy Weight Poor Lifestyle
3. Overweights

65+ age group

Healthy Ageing

6.1% of people **providing unpaid care** are in **bad or very bad health**

This is better than the city average

25.1% of people over 65 years old have an **illness that limits their daily activities**

This is close to the city average

957 people per 100k are living in **residential or nursing care** permanently

This is better than the city average

7.7% of people aged 65 years and over have **below average or very low wellbeing**

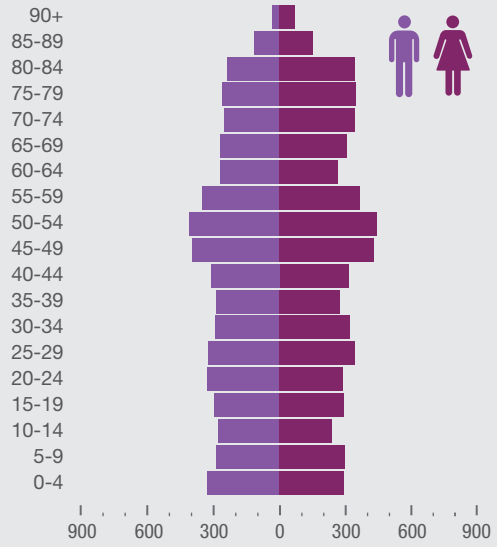
This is close to the city average

Your ward at a glance:

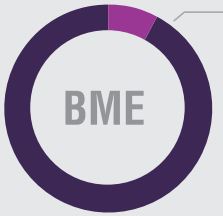
Wednesfield North

Wards

Total population: **11,019**



Key Demographic Facts



8.0%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
27.3
(City average: 33.2)

Key features from social marketing tool, MOSAIC

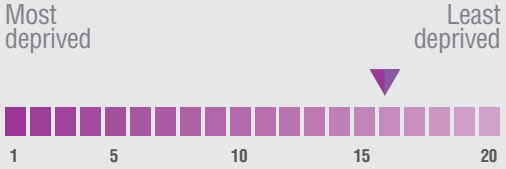
experian

Key feature 1
Mature age

Key feature 2
Homeowners

Key feature 3
Affordable housing

City deprivation ranking: **16**



0-24 age group

Starting and Developing Well

32.9% of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

19.9 **teenage pregnancies** per 1,000 under-18 yr olds

This is better than the city average

43.3 children per 10,000 are in **Local Authority Care**

This is better than the city average

Childhood obesity

25.2% of children at **year 6 are obese**

This is close to the city average

25-64 age group

Healthy Life Expectancy

3.3% claimed **unemployment benefits** in November 2017

This is close to the city average

13.8% of houses with one or more **category 1 hazards** identified

This is better than the city average

Predominant clusters from Healthy Lifestyle survey

1. Healthy Eaters
2. Healthy Weight Poor Lifestyle
3. Overweights

65+ age group

Healthy Ageing

8.4% of people **providing unpaid care** are in **bad or very bad health**

This is close to the city average

31.1% of people over 65 years old have an **illness that limits their daily activities**

This is worse than the city average

2,316 people per 100k are living in **residential or nursing care** permanently

This is close to the city average

5.7% of people aged 65 years and over have **below average or very low wellbeing**

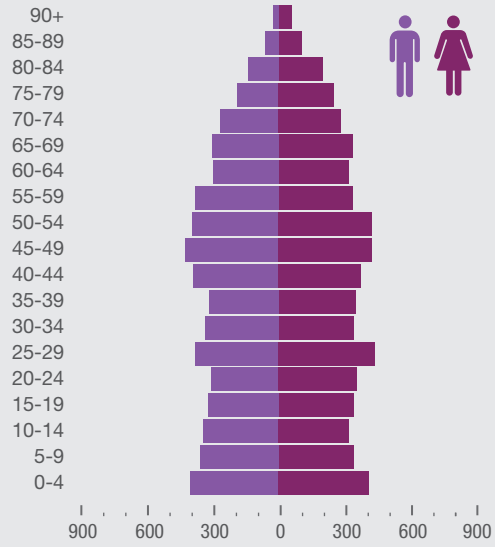
This is better than the city average

Your ward at a glance:

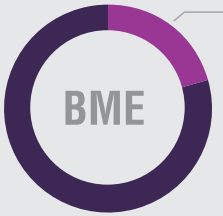
Wednesfield South

Wards

Total population: **11,510**



Key Demographic Facts



20.7%
of the population is
Black or Minority Ethnic
(City average: 32%)

Deprivation score:
27.9
(City average: 33.2)

Key features from social marketing tool, MOSAIC

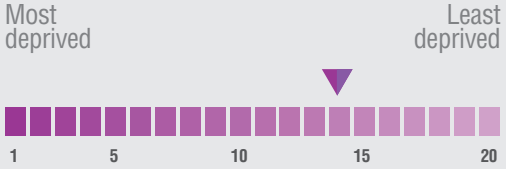
experian

Key feature 1
Elderly

Key feature 2
Living alone

Key feature 3
Low income

City deprivation ranking: 14



0-24 age group

Starting and Developing Well

35.9%
of pupils achieved grade 9-5 English and Maths GCSE

This is close to the city average

24.7
teenage pregnancies per 1,000 under-18 yr olds

This is close to the city average

63.0
children per 10,000 are in **Local Authority Care**

This is close to the city average

Childhood obesity

21.7%
of children at **year 6 are obese**

This is better than the city average

25-64 age group

Healthy Life Expectancy

3.6%
claimed **unemployment benefits** in November 2017

This is close to the city average

15.0%
of houses with one or more **category 1 hazards** identified

This is close to the city average

Predominant clusters from Healthy Lifestyle survey

1 **Overweights**

2 **Healthy Weight Poor Lifestyle**

3 **Healthy Eaters**

65+ age group

Healthy Ageing

6.9%
of people **providing unpaid care** are in **bad or very bad health**

This is better than the city average

29.8%
of people over 65 years old have an **illness that limits their daily activities**

This is worse than the city average

652
people per 100k are living in **residential or nursing care** permanently

This is better than the city average

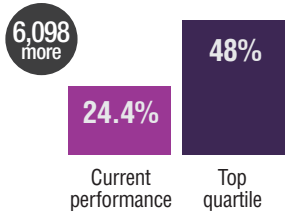
10.2%
of people aged 65 years and over have **below average or very low wellbeing**

This is close to the city average

Contracted services

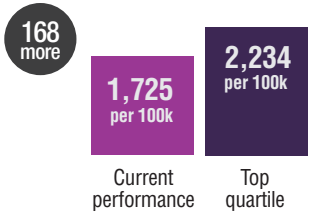
We aim to improve the performance of our contracted services to be in the top 25% of the country. This performance level is described as “top quartile”. This will help us to deliver the key priorities under each of the workstreams. This equates to the following performance standards which will be driven through our contracts.

NHS Health Checks



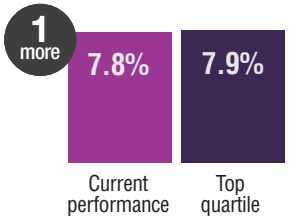
40 - 70 year olds
6,098 extra health checks
needed per year to hit top quartile

STI Screening

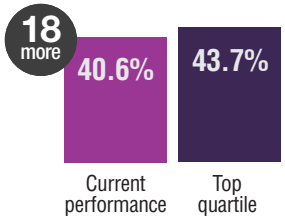


Chlamydia
168 more people detected
needed to hit top quartile

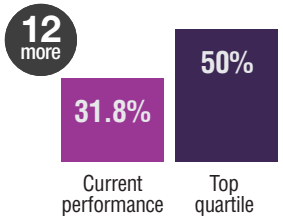
Drugs and Alcohol Treatment Completion Rates



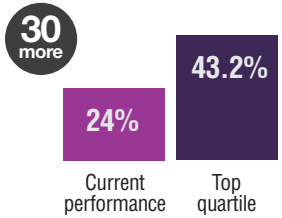
Opiates
1 more completion
needed to hit top quartile



Alcohol
18 more completions
needed to hit top quartile

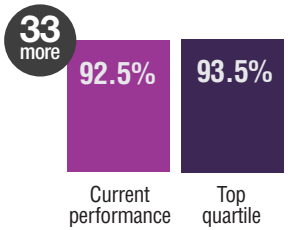


Non-opiates
12 more completions
needed to hit top quartile

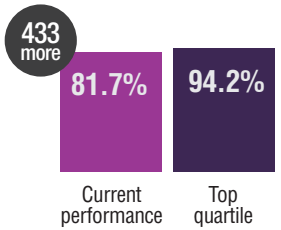


Alcohol and non-opiate
30 more completions
needed to hit top quartile

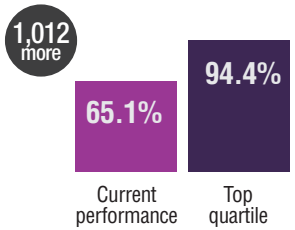
Healthy Child Programme (0-19s) four mandated check areas of the Health Visiting service



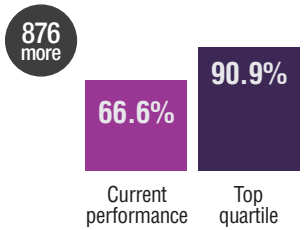
New born visit within 14 days
33 more visits
needed to hit top quartile



6-8 week review
433 more
needed to hit top quartile

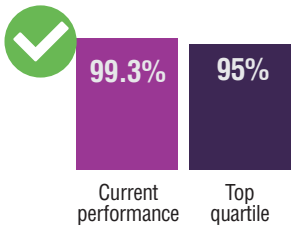


12 month review
1,012 more
needed to hit top quartile



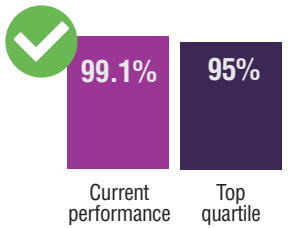
2-2½ year review
876 more
needed to hit top quartile

National Child Measurement Programme



Year R
We are already exceeding top quartile!

National Child Measurement Programme



Year 6
We are already exceeding top quartile!

Conclusion

Public Health has been through a restructure which has left the team skilled and excited to work differently. The new approach seeks to strengthen existing relationships with our wider colleagues; work at the population level on entrenched issues across the whole of the City; and target work at reducing inequalities on explicit issues in defined locations. This annual report has set the scene of an era of an ageing population with complex health needs, increasing austerity and a recognised growing increase in the gap of life expectancy between the richer and poorer regions across Britain. This could make our job tougher and we could see a decrease in our key indicator of healthy life expectancy.

However, a true marker of our success to embed our new model of working, vision and work plans will be that next year's Annual Report is written in partnership with the whole system and can demonstrate achievements in areas such as joint planning and project initiation; short, medium and longer-term plans to tackle entrenched problems in the system whilst reducing inequalities. We should also see improved performance in our services due to a more collaborative and supportive approach with providers.

This year we are taking our first steps in the journey of meeting our 2030 vision, by which time we aspire that life expectancy for men will have improved to 81 years and to 84 for women. We will also see improvements in healthy life expectancy in men to 66 and in women to 69 years of age whilst reducing the gap in life expectancy between the richest and poorest for men to eight years and for women to six years.

Appendix 1. Ward indicators

Compared to city avg. Worse Similar Better

Starting and Developing Well

Ward	0-24 population	Educational attainment % achieving a 9-5 English and Maths GCSE 2016/17	Infant mortality rate per 1,000 2007-2016	Under 18 conception rate per 1,000 2013-15	% Children in poverty – Income deprivation affecting children 2015	LAC rate per 10k population 2018	Oral health – mean dmft in children aged 5 2014/15	% Obese at year R 2012/13-2016/17	% Obese at year 6 2012/13-2016/17
Bilston East	5005	24.2	6.7	35.9	43.0	117.7	1.0	15.5	30.4
Bilston North	3869	31.9	8.1	40.4	35.2	96.9	0.9	11.5	29.3
Blakenhall	4215	42.1	9.9	26.3	25.6	99.6	1.3	16.0	28.1
Bushbury North	3437	28.1	9.0	28.3	26.4	105.6	0.7	9.4	25.9
Bushbury South and Low Hill	6363	24.6	6.0	49.0	43.2	190.2	1.1	13.8	28.1
East Park	4248	25.4	2.1	55.5	43.6	197.9	1.1	12.8	27.2
Ettingshall	5578	29.5	7.2	34.2	39.5	189.6	1.5	12.8	25.9
Fallings Park	4008	27.5	6.9	37.5	36.2	134.5	0.9	11.5	28.8
Graiseley	3926	38.9	3.4	35.9	30.2	139.0	1.4	12.6	25.5
Heath Town	5505	34.2	8.1	42.3	38.3	119.5	1.5	14.3	27.1
Merry Hill	3425	42.3	7.2	22.9	18.5	62.8	0.7	11.0	21.6
Oxley	4124	31.5	6.9	27.9	31.9	81.5	0.7	14.5	26.1
Park	3523	44.7	5.2	34.9	25.1	98.0	1.0	12.0	22.5
Penn	3313	47.2	6.3	10.1	10.9	<25	0.5	9.9	20.5
Spring Vale	3667	29.4	4.8	18.5	30.5	56.3	0.7	11.6	25.7
St Peter's	5843	29.7	11.2	33.7	35.4	117.7	1.8	13.5	29.9
Tettenhall Regis	3172	47.3	3.5	7.2	12.5	39.2	0.8	7.9	23.5
Tettenhall Wightwick	2587	38.7	3.3	12.3	14.9	<25	0.6	9.2	17.7
Wednesfield North	2932	32.9	5.2	19.9	24.0	43.3	0.6	13.4	25.2
Wednesfield South	3456	35.9	4.8	24.7	27.1	63.0	0.6	12.6	21.7
Wolverhampton	82196	35.2	6.6	31.0	31.3	110.6	1.01	12.4	26.0
West Midlands	-	39.3	4.3	26.4	-	75	0.7	10.4	21.4
England	-	39.1	5.9	22.6	19.9	62.0	0.8	9.4	19.4

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Compared to city avg. Worse Similar Better

Healthy Life Expectancy

Ward	24-64 population	Unemployment – % claiming benefits Jan-18	% highest qualification degree/NVQ 5 or higher for those aged 16-64 2016	DSR per 100,000 Alcohol admissions 2013/14-2015/16	% Smoking prevalence 2016	% of houses with 1 or more cat. 1 HHSRS hazard identified 2016	DSR rate per 100k diabetes prevalence 2017	Predominant cluster from healthy lifestyles survey 2016	Predominant cluster 2 from healthy lifestyles survey 2016	Predominant cluster 3 from healthy lifestyles survey 2016
Bilston East	7459	4.8	12.1	336.2	26.0	13.4	1511.3	Healthy Weight Poor Lifestyle	Obese and Average Wellbeing	Overweights
Bilston North	6145	3.7	7.6	303.6	19.7	14.9	1182.1	Healthy Weight Poor Lifestyle	Overweights	Obese & Average Wellbeing
Blakenhall	6588	3.9	23.7	453.8	13.0	20.9	2269.8	Healthy Weight Poor Lifestyle	Overweights	Healthy Eaters
Bushbury North	6059	3.3	10.0	235.9	18.3	14.5	1352.3	Healthy Weight Poor Lifestyle	Used to Smoke	Healthy Eaters
Bushbury S. & Low Hill	7810	5.6	14.9	401.3	31.9	17.3	1733.2	Healthy Weight Poor Lifestyle	Overweights	Obese and Average Wellbeing
East Park	6478	6.1	12.9	285.4	20.4	14.0	1459.3	Healthy Weight Poor Lifestyle	Obese and Average Wellbeing	Used to Smoke
Ettingshall	7955	5.0	11.8	477.4	30.9	17.7	2035.2	Healthy Weight Poor Lifestyle	Overweights	Used to Smoke
Fallings Park	6164	4.3	14.2	248.5	20.6	17.2	1406.6	Overweights	Healthy Weight Poor Lifestyle	Obese and Average Wellbeing
Graiseley	6856	5.1	17.3	458.5	26.0	20.9	1779.6	Healthy Weight Poor Lifestyle	Overweights	Healthy Eaters
Heath Town	8090	5.5	12.9	392.8	27.9	13.2	1543.6	Healthy Weight Poor Lifestyle	Obese and Average Wellbeing	Overweights
Merry Hill	6071	3.0	11.2	452.5	28.0	15.4	1129.9	Healthy Weight Poor Lifestyle	Overweights	Drinkers and Smokers
Oxley	6822	3.9	14.0	259.6	22.1	12.3	1357.9	Healthy Weight Poor Lifestyle	Overweights	Healthy Eaters
Park	7001	5.0	29.6	462.1	17.3	21.9	1487.9	Vigorously Active	Healthy Weight Poor Lifestyle	Drinkers and Smokers
Penn	6377	1.7	31.3	146.1	12.8	17.7	1059.1	Healthy Eaters	Healthy Weight Poor Lifestyle	Overweights
Spring Vale	5956	3.3	13.5	257.0	22.1	14.6	1063.6	Healthy Weight Poor Lifestyle	Obese and Average Wellbeing	Overweights
St Peter's	7194	6.2	17.1	476.3	24.6	17.5	2329.3	Healthy Weight Poor Lifestyle	Overweights	Used to Smoke
Tettenhall Regis	5855	1.8	29.0	207.3	12.3	15.8	1042.7	Healthy Eaters	Healthy Weight Poor Lifestyle	Drinkers and Smokers
Tettenhall Wightwick	5320	1.9	32.5	137.8	14.2	11.7	1009.7	Healthy Eaters	Healthy Weight Poor Lifestyle	Overweights
Wednesfield North	5376	3.3	14.1	261.8	20.4	13.8	1149.2	Healthy Eaters	Healthy Weight Poor Lifestyle	Overweights
Wednesfield South	5853	3.6	16.1	299.3	29.3	15.0	1118.0	Overweights	Healthy Weight Poor Lifestyle	Healthy Eaters
Wolverhampton	131429	4.2	16.6	325.7	22.5	15.9	1451.0	Healthy Weight Poor Lifestyle	Overweights	Healthy Eaters
West Midlands	-	2.4	31.5	-	15.4	-	-			
England	-	1.9	37.9	-	15.5	-	-			

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Compared to city avg. Worse Similar Better

Healthy Ageing

Ward	65+ population	% people providing unpaid care provision 2011	% people providing unpaid care in bad or very bad health 2011	% Limiting illness which limits daily activities a little or a lot 2016	Male Life expectancy at birth 2012-16	Female Life expectancy at birth 2012-16	DSR per 100,000 falls admissions in 65+ 2011/12-2015/16	DSR per 100,000 respiratory admissions in 65+ 2011/12-2015/16	DSR rate per 100,000 dementia prevalence 2017	Permanent placements in residential or nursing care rate per 100,000 65+ 2015/16-Oct 2017/18	Community based service provision* rate per 100,000 65+ 2015/16-Oct 2017/18	% below average or very low wellbeing 65+ 2016	Income Deprivation Affecting Older People Index (IDAOPI) 2015	% Fuel poverty 2016
Bilston East	2078	10.6	10.2	28.5	76.3	80.9	2305.3	2106.2	186.0	1660	6249	14.6	35.9	11.5
Bilston North	2283	11.4	8.2	20.4	78.0	82.0	1938.0	1781.4	137.0	1596	4788	8.1	25.6	11.4
Blakenhall	1987	10.3	8.3	21.4	76.2	79.7	1880.1	1817.2	290.6	8622	4682	12.8	29.5	16.4
Bushbury North	2475	12.2	7.8	22.6	77.1	83.8	1910.8	1795.9	126.6	1817	4636	8.3	22.3	10.7
Bushbury S. & Low Hill	1680	9.7	9.0	28.0	73.8	77.8	2722.1	2541.4	251.5	3945	5399	21.6	34.9	17.3
East Park	2166	9.9	10.3	28.9	77.3	80.4	2407.9	2296.7	168.3	1646	4796	10.9	31.6	12.5
Ettingshall	1712	9.2	7.4	18.5	75.5	80.7	1991.2	1704.3	245.7	2060	4709	12.7	34.5	15.3
Fallings Park	2027	11.2	7.1	30.3	77.0	81.9	2154.5	1978.5	193.0	2180	4016	7.2	25.6	13.1
Graiseley	1825	10.5	7.2	22.3	74.8	80.5	1988.3	1807.7	267.7	4864	6180	10.5	31.5	15.8
Heath Town	1495	8.3	9.3	24.3	74.9	78.6	2209.8	2009.7	212.9	4304	4615	10.6	35.8	18.4
Merry Hill	2435	13.0	7.1	34.1	79.6	82.9	1996.4	1348.5	110.0	143	4871	20.0	19.9	11.3
Oxley	1877	10.5	7.3	25.2	78.1	82.3	2130.5	1609.7	135.8	1673	4047	9.4	27.4	9.7
Park	1956	10.3	6.5	18.6	76.5	79.7	1822.4	1675.9	306.6	9670	4419	14.6	21.4	16.2
Penn	2818	12.6	4.6	21.5	81.4	83.5	1957.8	1262.9	183.2	3851	4374	5.9	14.1	10.9
Spring Vale	2431	11.2	9.1	27.5	78.5	83.8	2556.2	1670.3	198.7	3396	5102	4.4	24.3	10.4
St Peter's	1007	7.5	11.0	17.4	76.6	83.0	1556.4	1907.8	193.7	154	8506	15.6	43.5	19.2
Tettenhall Regis	2793	12.7	5.7	28.4	78.9	83.3	1870.9	1290.9	182.7	3039	3317	4.9	10.9	10.4
Tettenhall Wightwick	3039	13.4	6.1	25.1	81.5	84.8	2125.8	1261.0	132.7	957	3444	7.7	14.9	9.9
Wednesfield North	2711	13.1	8.4	31.1	79.1	82.9	2078.9	1802.1	166.1	2316	4318	5.7	21.6	10.1
Wednesfield South	2201	11.5	6.9	29.8	77.9	83.3	1875.7	1715.2	108.4	652	4455	10.2	21.8	11.1
Wolverhampton	42996	10.9	7.8	25.1	77.5	81.8	2067.5	1744.0	189.9	3228	4762	10.3	25	13.1
West Midlands	-	10.2	7.1	19.0	78.8	82.7	2068.0	-	-	-	-	-	-	-
England	-	11.0	6.6	17.6	79.5	83.1	2114.0	-	-	-	-	-	16.2	10.6

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Appendix 2. Healthy Lifestyle Clusters

The Wolverhampton population was segmented into 10 clusters following a lifestyle survey of over 9,000 representative individuals.

Cluster 1: **Vigorously Active**

643, 8.7% of total sample population, 22,326 of Wolverhampton population

Individuals in this cluster have higher wellbeing compared to the overall population. The majority of this cluster have never smoked and are more likely to be a healthy weight. People in this cluster are much less likely to be high risk drinkers and more likely to eat healthily, however, a substantial number still eat unhealthily.

Dominant features:

- Male
- Under 39
- Asian ethnic background
- Mainly working population
- Students
- Most likely to have higher level qualifications

Ward with largest distribution:

- Park
- Spring Vale

Cluster 2: **Healthy Eaters**

924, 12.5% of total sample population, 32,078 of Wolverhampton population

More likely to have higher wellbeing compared to the overall population. People in this cluster are less likely to be smokers and high-risk drinkers. They are also substantially less likely to be obese and more likely to be a healthy weight, however, slightly more in this cluster are overweight than compared to the overall average. Individuals in this cluster are not vigorously active.

Dominant features:

- Female
- Over 65
- Mainly white
- Working/retired
- Deprived under represented

Ward with largest distribution:

- Tettenhall Wightwick
- Tettenhall Regis

Cluster 3:
Used to Smoke

757, 10.2% of total sample population, 26,175 of the Wolverhampton population

These individuals are most likely to have average wellbeing. Although most of this cluster are not vigorously active they are more likely to be moderately active. Healthy eating is not significantly different from the overall population level. This cluster is less likely to abstain from drinking alcohol compared to the overall population, however, they have similar levels of high risk drinking. People from this cluster are more likely to be overweight and significantly more likely to be obese.

Dominant features:

- Slightly more Males
- Over 70
- White over represented
- Retired over represented
- Deprived
- Less likely to have high level qualifications

Ward with largest distribution:

- St Peters
- Bushbury North

Cluster 4:
Healthy Weight Poor Lifestyle

1529, 20.6% of total sample population, this is the largest cluster, 52, 864 of the Wolverhampton population

People in this cluster are more likely to have average wellbeing. Despite being a healthy weight nearly all the people in this cluster eat unhealthily. Compared to the overall population people in this cluster are more likely to be smokers. People from this cluster mainly abstain from drinking and none are high risk drinkers. They are much less likely to engage in vigorous activity.

Dominant features:

- More females
- More aged under 29
- Deprived
- Over representation of students

Ward with largest distribution:

- Bushbury South and Low Hill
- Graiseley

Cluster 5:
Overweights

1137, 15.3% of total sample population, progression from cluster 4, 39,263 of the Wolverhampton population

People in this cluster are more likely to have average wellbeing. All of the people in this cluster eat unhealthily however, most do not smoke and none are high risk drinkers. This cluster is much less likely to engage in vigorous activity.

Dominant features:

- Equal gender
- Younger population
- Over-representation of Asian population
- Most work full time also high retired
- More likely to have no qualifications

Ward with largest distribution:

- Graiseley, St Peters
- Ettingshall

Cluster 6:
Drinkers and Smokers

685, 9.2% of total sample population, 23,609 of the Wolverhampton population

Nearly half of people in this cluster are current smokers, significantly higher than the overall population. The majority of those in this cluster have average wellbeing. For this cluster people are more likely to be overweight and less likely to be obese compared with the overall population. For this cluster activity levels and healthy eating behaviour are also worse than the overall population.

Dominant features:

- Males
- Aged 25-49
- White
- Deprived under-represented
- Work full time
- Unemployed over represented

Ward with largest distribution:

- Tettenhall Regis
- Graiseley

Cluster 7:
Obese and Average Wellbeing

908, 12.2% of total sample population, 31,308 of the Wolverhampton population

The overwhelming majority of those in this cluster have average wellbeing. People in this cluster have similar healthy eating behaviour to the overall population and are less likely to be vigorously/moderately active. However most of this cluster do not smoke and are most likely to abstain or drink at low risk.

Dominant features:

- Females
- Over 50
- Slight over-representation of black population
- Work full time but retired over represented
- More likely to have no qualifications

Ward with largest distribution:

- Bilston East
- Heath Town

Cluster 8:
Underweights

208, 2.8% of total sample population, 7,185 of the Wolverhampton population

The majority of this cluster eat unhealthily and are much more likely to be smokers. More of this cluster abstains from drinking. This cluster has a similar profile for wellbeing as the overall population. Moderate activity levels for this cluster are just below the overall population average whilst vigorous activity is slightly higher.

Dominant features:

- Female
- Under 29
- Asian population over-represented
- Deprived
- Students and unemployed over represented

Ward with largest distribution:

- Bushbury South and Low Hill
- Fallings Park

Cluster 9:
Below Average Wellbeing

456, 6.2% of total sample population, 15,911 of the Wolverhampton population

People in this cluster are much more likely to be obese, smoke and not take part in vigorous/moderate activity. In addition, they are much more likely to eat unhealthily. Rates of high risk drinking for this cluster are a little lower than the levels for the overall population and they are slightly more likely to abstain from alcohol.

Dominant features:

- Slightly more females
- Over 40
- White
- Deprived
- Retired/ long term sick disabled
- More likely to have no qualifications

Ward with largest distribution:

- Bushbury South and Low Hill
- Merry Hill

Cluster 10:
Very Low Wellbeing

167, 2.3% of total sample population, progression from cluster 9, 5,902 of the Wolverhampton population,

People in this cluster are much more likely to eat unhealthily, not take part in moderate/vigorous activity, smoke and be obese. However, they are more likely to abstain from drinking alcohol but have higher risk drinking rates similar to the overall population level.

Dominant features:

- Slightly more females
- 45-64
- White
- Deprived
- Unemployed/ long term sick-disabled
- More likely to have no qualifications

Ward with largest distribution:

- Bushbury South and Low Hill
- Merry Hill
- Bilston East

You can get this information in large print, braille,
audio or in another language by calling 01902 551155

wolverhampton.gov.uk 01902 551155

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