ANNUAL REPORT

2017/18

NHS

Wolverhampton

Clinical Commissioning Group

Contents

FOREWORD ACCOUNTABLE OFFICER

During 2017-18 we have continued to build on our achievements as a Clinical Commissioning Group (CCG) as we work to improve the health and care for the people of Wolverhampton. During an increasing difficult financial period across the health sector, we have been able to maintain financial stability which has helped us to continually drive improvements. This year we have also taken on fully delegated responsibility for commissioning our Primary Care services across the City.

In Wolverhampton we highly value the patient's opinion. We regularly look to involve patients in commissioning in many different capacities: from our Lay Members who are active members of our various committees; our regular meetings with PPG Chairs and Citizen Forum leaders; to the annual engagement we do for our Commissioning Cycle of Commissioning Intentions out and about in the city meeting people and asking them about the services they use, both in the acute sector and in the community.

We are an active member of the Black Country and West Birmingham Integrated Care System (formally Sustainability and Transformation Plan) working towards driving system changes across the region. There are 18 partners including NHS commissioners and providers and the local authorities looking to address the health and welling gap, care and quality gap and the financial gap. We are continuing to develop this work at scale and pace.

Our Integrated Care System (ICS) plan is compiled of five workstreams: Place Based Care, Integration across the acute providers, Children & Maternity, Wider determinants of health and Mental Health. Steven Marshall, WCCG's Director of Strategy and Transformation is the lead for the Mental Health workstream which has made considerable progress during the year. Working with our Black Country CCG partners, we have agreed a number of mental health services to focus on in the coming months to commission and deliver on the STP footprint. We are pleased to be the forefront of this work.

The four CCGs in the Black Country, Sandwell and West Birmingham, Dudley, Walsall and ourselves, have formed a Joint Commissioning Committee to enable us to commission some services at scale for the people across the Black Country. This work is complemented by the work of a Clinical Leadership Group which is working to develop the Black Country and West Birmingham clinical strategy.

As part of our commitment to the GP Five Year Forward View locally, we have mobilised our Primary Care workforce into groupings. Our New Models of Care in Wolverhampton has taken the form of four different groups working together across the City. Some practices have chosen to Vertically Integrate with The Royal Wolverhampton NHS Trust, a number of others belong to models Primary Care Homes 1 and 2, and the fourth group Unity have formed a Medical Chamber model. These groupings allow improving access for the public to services by the sharing of workforces, resources and delivering services across practices. This year we have been able to work with the groups to provide GP appointments during extended hours, for both Bank Holidays and on Saturdays. As a CCG we have continued to support and facilitate the formation and resilience of these groupings with the provision of a dedicated Primary Care team including Group Managers who have helped to build and maintain a clearer working relationship with GPs and Community Staff.

A Primary Care Counselling Service was established, and a three year contract from 1 April 2018 has now been awarded due to the success of the pilot, which was evidenced by improved outcomes to service users.

Digitally this year we were one of the first CCG's to implement GP Remote Consultation for GP Practice groups, which supports extended opening hours and the ability of Clinicians to

hold and record consultations with patients from any of the practices within the GP groups. We have also provided GP surgeries with a texting solution that increases the range of texts that they can send to patients, whilst also allowing patients to cancel appointments by text when necessary.

We continue to meet regularly throughout the year with our GP members to engage, update and share information with them and to listen to their views on service developments.

This year we met with over 300 members of the public to share their opinions with us during our Commissioning Intentions events. We were told that, *"Being able to see GPs in other practices is very good"*. Our GP groups have worked together in their groups to deliver extended hours with both Saturday Hubs and opening over the Bank Holidays this year.

"Would like to talk to someone and not have to wait in a GP surgery", was another comment from the public. We have trained many of our GP staff in Care Navigation since February 2018 to help signpost patients to more appropriate local services.

Over the past year we have continued to work with all our partners locally, including our acute and community provider, our mental health provider and our local authority.

We have continued to develop the Wolverhampton Shared Care Record and have now started working with Walsall to identify synergies and ways that we can bring our digital systems together to create a combined Wolverhampton and Walsall shared care record.

Wolverhampton Public Health Department this year has had to address some financial challenges. We have worked closely with our colleagues on both the development of the Joint Strategic Needs Assessment (JSNA), and also the necessary changes in their commissioning of some local services to work within their financial envelope.

This year we welcomed Dr Salma Reehana as our new Clinical Chair. She is a local GP and a member of Primary Care Home 2. She brings with her a wealth of experience and an interest in the development of new models of Primary Care and GP education.

Helen Hibbs

Accountable Officer

PERFORMANCE REPORT

About us

Wolverhampton Clinical Commissioning Group (WCCG) was set up under the Health and Social Care Act 2012. We were fully authorised by NHS England in October 2013 and have a budget of £405.516 million to buy healthcare services for people living in Wolverhampton. We are a clinically led organisation, comprising 42 GP practices, and we provide healthcare services for the circa 270,000 patients who are registered with a GP in Wolverhampton.

Our local population

Wolverhampton is located in the Black Country in the West Midlands. It currently has a population of 258,100 (2016) which is estimated to grow to 263,100 by 2021 and 275,900 by 2030. Wolverhampton is a diverse city and 32 per cent of our population belongs to black minority ethnic (BME) communities compared to 15 per cent for England.

Wolverhampton is one of the most densely populated local authority areas in England with a population density of 34 people per hectare. Wolverhampton is amongst the most deprived areas within the country ranking as the 11th most deprived local authority area in England. In recent years unemployment has fallen in the city but remains the sixth highest unemployment rate per local authority in England.

Social and community issues

The previous trend of increasing life expectancy for males and women in Wolverhampton has begun to level off in recent years and the gap to England is not increasing. In addition healthy life expectancy data shows that in Wolverhampton, men and women live 7.0 and 4.6 years respectively in poorer health than the England average. In Wolverhampton the average man and woman can expect to live the last 21 years and 21.9 years of their lives in poor health. It is these years lived in poor health that leads to higher demand on our health and social care services in Wolverhampton.

There are six conditions which account for over half of the difference in life expectancy that exists between Wolverhampton and England. These are heart disease, stroke, infant mortality, lung cancer, respiratory illness and alcohol. The impact of these conditions is seen disproportionally in the most disadvantaged communities.

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

Rates for childhood obesity in Wolverhampton for primary school children remain above national average, at year 6, 26.7% of children are obese compared to 20% for England. Obesity rates are increasing in children aged 10-11 years old, with especially high levels in the most deprived wards.

Our structure and commissioning activities

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

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

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

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

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

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

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

Black Country and West Birmingham Sustainability and Transformation Partnership

We have continued to support the Black Country and West Birmingham Sustainability and Transformation Partnership, which is working towards forming an integrated care system.

The aim of the Partnership is to develop and deliver financially and clinically sustainable health and care plans across the Black County that will improve the health and wellbeing of our residents/citizens. The Partnership has identified three distinct but interconnected aims or 'accountabilities' that sum up what we are trying to achieve together. They are:

- Integrating hospital, community, primary and social care services on a place by place basis

- Collaborating as NHS partners across the Black Country on key areas such as mental health and cancer services that will enable us to deliver more and higher quality healthcare to our communities

- Working at scale across the Black Country with the Combined Authority, our local councils and other stakeholders to address the wider, economic and social determinants of health that can make such a difference to people's wellbeing.

We have made practical headway too and our achievements over the financial year have included:

- Introduced Maternity Voices to engage new mums and mums-to-be in the co-production of **more personalised, family-friendly maternity services** across the Black Country
- Published our workforce plan for primary care that will ensure we have the skills, workforce and infrastructure to commission new place-based models of care with general practice as the centre
- Delivered Black Country-wide **winter campaign** that focused on self-care, 111/urgent care services and flu vaccine uptake, using events, media and social media to encourage behaviour change. Full campaign evaluation will be carried out in May
- Brought together more than 100 health and care professionals to share their ideas around **perinatal mental health**. This resulted in a pilot mental health liaison clinic led by a consultant psychiatrist and providing specialist evidence-based treatment for women in the Black Country
- Secured **extra funding** from the Chancellor's autumn budget to support urgent care. The money has been allocated to the £2.7m urgent care centre under construction at Russells Hall Hospital in Dudley
- Published E*conomic Impact of NHS Spending in the Black Country* to help us understand the **impact of our ICS/health and care decisions on the wider Black Country economy.**

As the year has progressed, so too has our understanding of the Partnership's longer-term role and responsibilities in shaping sustainable health and care. We are now looking at how we can work together even more closely as an Integrated Care System across the Black Country and West Birmingham. This will require a more formal structure, and during the early months of 2018/19 the Partnership will be recruiting a part-time, independent chair and a lead/SRO.

Sustainable development

The CCG's sustainability responsibilities were met in 2017/18 and will continue to develop throughout 2018/19. The Governance Statement highlights the work of our accommodation partner and outlines our plans to work effectively as a CCG whilst working robustly with our providers to ensure the services we commission are delivered in a sustainable way. We also continually examine our internal processes to ensure we meet our obligations through initiatives such as the use of technology to further embed paperless working, and the introduction of a Sustainable Development Management Plan in line with national best practice.

Factors likely to affect future development and performance

Risks and uncertainties

The CCG has undertaken considerable work throughout the year to ensure that it clearly understands and takes action to address the risks that it faces. This has included refocussing our Governing Body Assurance Framework (GBAF) to reflect risks to us achieving our three strategy objectives:-

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

The GBAF assesses the overall level of risk to the CCG achieving each of these objectives, recognising the following areas of risk:-

Improving the quality and safety of the services we commission

As well as the inherent risk associated with specific concerns about safety concerns with our providers (which during the year have included aspects of care at the Vocare Urgent Care Centre and maternity services at RWT), the CCG recognises there is an underlying risk that mitigating action to address such concerns may divert resources from overall improvements to the health systems. The CCG continues to mitigate risks in these areas through our robust quality management approaches, which ensure concerns about quality are addressed at the earliest possible opportunity.

Reducing health inequalities in Wolverhampton

In order to meet the challenges facing our health and care system, the CCG recognises the need to work differently. This includes working with our Member practices, providers and other partners in new and innovative ways, with the ultimate aim of a more integrated system that will help to address health inequalities. This creates a number of risks balancing the priorities and challenges of different organisations, whilst maintaining positive working relationships to deliver systemic change. In particular, we are working closely with our member practices to deliver our ambitious Primary Care Strategy, bringing significant improvements in care for patients in primary care in Wolverhampton. The scale of this change is unprecedented, bringing inherent risks as CCG staff, GPs and practice staff implement significant changes to their ways of working. This comes on top of existing high demand for services and a recognised workforce challenge in Wolverhampton. The CCG's consistent and collaborative approach to working closely with all our partners, both in Wolverhampton and further afield, supports the overall mitigation of these risks by maintaining a focus on delivering outcomes that will support improvements in health inequalities across Wolverhampton.

System effectiveness delivered within our financial envelope

In common with all public sector organisations, the CCG must maintain a clear focus on delivering our responsibilities with the financial resources available to us in an environment of significant change. This means that there is significant pressure on delivering existing responsibilities within existing staff resources. In particular, a number of key staff who have significant roles to play in meeting CCG commissioning, finance and performance duties are also working on programmes across the health and care system in the Black Country through the STP. The nationally driven focus on closer working across the Black Country also brings with it some additional risks, including the potential to highlight tensions between

both different organisational financial priorities, and efforts to develop locally appropriate models of care and strategic commissioning across the Black Country footprint affecting relationships across the system. This in turn potentially affects local work such as the Better Care Programme of work to integrate health and social care services and plans to make improvements in estates across Wolverhampton. The CCG has a strong track record of delivery of our responsibilities through our robust systems and processes, and we continue to work through these to mitigate the overall level of risk across the system.

Whilst we recognise that we face challenges and uncertainties, the CCG's comprehensive approach to managing risks by focussing and taking action and our focus on delivering our strategic priorities will ensure that we are equipped to meet them.

Financial review of the year

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

2017/18 Performance	Target	Actual
Statutory duties:		
Expenditure not to exceed income	£11.274m surplus	£11.286m surplus
Capital resource use does not exceed the amount specified in Directions	Nil	Nil
Revenue resource use does not exceed the amount specified in Directions	£405.52m	£405.52m
Revenue administration resource use does not exceed the amount specified in Directions	£5.535m	£5.326m
Non-statutory duties:		
Better Payment Practice Code: NHS	95%	99%
Better Payment Practice Code: Non-NHS	95%	98%
Cash drawdown target	Achieve	Achieved
QIPP (Quality, Innovation, Productivity and Prevention)	£10.615m	£10.615m

The CCG commenced the financial year with a target surplus of £9.130m. During the financial year, CCGs were required to hold their 0.5% of 1% reserve as a system risk reserve. In March 2018 NHS England (NHSE) asked CCGs to release the 0.5% reserve and therefore increase their surplus to compensate for the worsening national provider financial position. In addition, NHSE released the benefit of prices changes to Category M drugs (drugs coming off patent)to CCGs which also increased the surplus. For WCCG the target surplus therefore increased from £9.130m to £11.274m.

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

WCCG has managed its responsibilities within a financial envelope of £405.516m which encompasses both the commissioning of healthcare services, Delegated Primary Care and management 'running' costs. 2017/18 is the first year of full delegation for Primary Care.

The healthcare allocation (Programme Costs) is determined by NHSE and using a complex formula designed to take into account the health needs of our population. It has been spent on healthcare services such as those delivered by RWT, BCPFT and a wide range of voluntary/third sector organisations.

The Running Cost allocation pays for the cost of employing staff, running the organisation and all the support systems we need to commission and monitor services. The CCG spent £5.326m, approximately £19.37 per head of population on Running Costs a reduction on last year (£21.87). The CCG has developed an organisational structure which best supports the delivery of the CCG's 2-5 year Operating Plan. It ensures that decisions are made with effective clinical input through individual clinicians and membership practices, and sufficient resource is allocated to monitor the impact of our decisions.

During the year the CCG has received additional allocations totalling £4.048m. The table below details the move between opening and closing allocations.

	Opening £ 'm	**Closing £'m**	**Increase £'m**
Programme allocation	352.326	355.201	2.875
Delegated Primary Care	34.477	35.65	1.173
Running Cost allocation	5.535	5.535	0
Surplus	9.130	9.130	0
Total	**401.468**	**405.516**	**4.048**

The table below summarises the CCG's performance against its financial allocation as at the end of March 2018 and reflects the financial position reported in the CCG's annual accounts.

	Annual Plan £m	**Actual £m**	**Variance under/(over) £m**	**Variance %**
Healthcare Allocations	390.85	390.85		
Running Cost Allocation	5.54	5.54		
Brought Forward Allocation	9.13	9.13		
Total Allocations	**405.52**	**405.52**		
Expenditure				
Acute Services	193.79	197.13	-3.34	-1.7%
Mental Health Services	36.25	36.72	-0.47	-1.3%
Community Services	48.55	47.74	0.81	1.7%
Continuing Care/Funded Nursing Care	14.49	13.92	0.56	3.9%
Prescribing	52.37	52.22	0.15	0.3%
Delegated Primary Care	35.65	34.43	1.22	3.4%
Other Programme Costs	6.24	6.74	-0.50	-8.1%
Reserves	3.52	0.00	3.52	100.0%
Running Costs	5.54	5.33	0.21	3.8%
Total Expenditure	**396.39**	**394.23**	2.16	0.5%
Revised Target (NHSE)	11.27	11.28	0.01	
Underspend in excess of Revised Target	0.00	0.01	0.01	

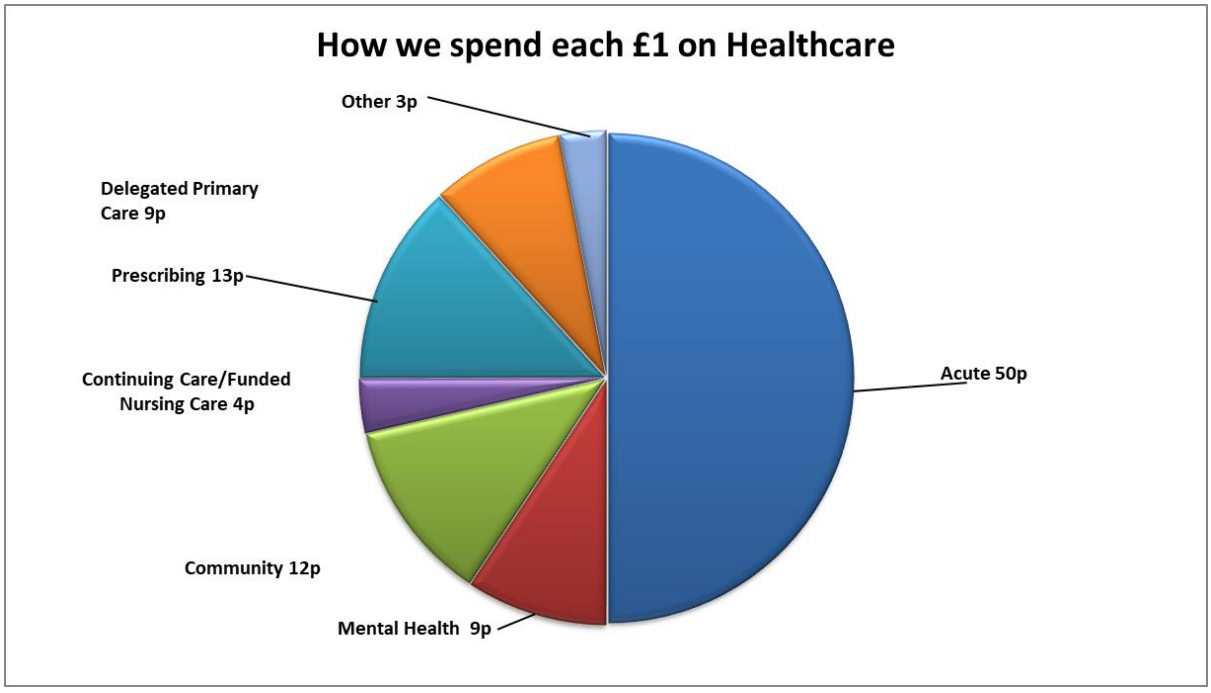
In achieving this position there were a number of significant variances from plan:

- Acute contracts were £3.34m, (1.70%) over plan which was mainly attributable to increased emergency admissions (predominantly in General Medicine). However, levels of elective activity have been much lower than anticipated
- Mental Health Service spend exceeded plan by £470k, and this reflects the complexity of care required by patients and the need for placements in out of area facilities
- Community Services underspent mainly due to the negotiation of an risk/gain cap on Better Care Fund and AQP underperforming
- Delegated Primary Care underspent mainly as a result of a large expenditure accrual in 16/17 (when NHSE managed Primary Care) being unwound and unutilised in 17/18.

Against a QIPP target of £10.615m there was a shortfall of £1.5m.

Spend per head of population

In 2017-18 the CCG spent an average of £1,419 per person on providing healthcare services to people registered with a WCCG practice. This is how we spent each £1 in 2017/18:



Our Accounts

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

The main assets that the CCG holds as at 31 March 2018 are short term receivables (amounts owed to the CCG by third parties) and the main liabilities are short term payables

(amounts owed to other parties by the CCG). The CCG does not hold any significant operational assets such as land, buildings and equipment, nor does it have any complex lease arrangements or long term liabilities.

Going Concern

The CCG has met all financial targets for the year, including containing our administrative running costs within the allowance of £5.535m million. Further, it is expected that CCG - commissioned services will continue to be provide in Wolverhampton beyond the date for which our financial statements relate. In preparing our annual financial statements, we have considered the CCG to be a "going concern".

How we're doing

Our strategy

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

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

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

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

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

- we want to reduce hospital admissions and provide more care closer to home through community-based services, improving co-ordination and access
- we will take on more responsibility for GP services and take full control of these in the future
- we will focus more on preventing illnesses, working with public health to look at lifestyle factors that increase the risk, including obesity. We will also work to improve uptake of the NHS Health Check programme
- we want to give patients better access to GPs, but also reduce pressure on practices through new ways of people accessing GPs – using new technologies for example - and we need to consider how we increase support
- we want to improve mental health services, provide better care and more choice to people with long-term mental health problems
- we will improve access to mental health treatment, crisis and home care so children and young people are treated in a timely manner by local services
- we will work to improve dementia diagnosis, treatment and care, and implement national standards for mental health service waiting times
- we are committed to providing good quality children's services and are working with public health to reduce Wolverhampton's high infant mortality rate which is currently one of the highest in England

- we want to improve co-ordination of services and care for children with special educational needs and disabilities to ensure appointments occur in a convenient place and time and reduce the amount of time spent out of a learning environment. We want better quality of care. We will continue to monitor the safety of services, will work to reduce healthcare associated infections and improve services based on patient feedback
- we also want to increase the uptake of personal health budgets
- we will continue to improve Information Technology (IT) in our GP practices to improve access to and sharing of information
- we want better seamless health and social care. We will work with the City of Wolverhampton Council (CWC) to provide joined-up health and social care that delivers high-quality services through best use of our joint investment. We will transform services in a way that is sensitive to local needs and sustainable for the long term.

Assurance performance

The CCG has continued to effectively performance manage and commission local healthcare services and this work has been recognised by NHS England who awarded WCCG an 'Outstanding Performance' rating for their annual assurance assessment for 2016/17. This achievement maintains WCCG's position in the top 10% of all CCG's nationally and one of only four CCGs to maintain this standard in successive years.

Primary care

Primary care strategy

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

Our strategy has been co-designed with our member practices. As a membership organisation we are committed to working with our GPs. We would like to continue to work together over the coming years as primary care develops in Wolverhampton.

As part of the Primary Care Strategy we established task and finish groups in 2016. The seven groups are focussed on delivering the strategy. The groups are responsible for developing primary care: Practices as Providers; Localities/Practice Groups as Commissioners; Primary Care Contracting; Workforce; Clinical Pharmacist Role; Estates, Information Management & Technology. Whilst excellent progress is being made, the work of the Clinical Pharmacist Task and Finish Group has ceased as this role is embedded in many practices across the city. Our Governing Body are kept sighted on the progress taking place for this and the GP 5 Year Forward View (GPFV) programme of work.

New Models of Care

In Wolverhampton our GP Practices have split into four different groups to help us shape primary and community services for the future. Our priority is to provide care that is easier to

access, in the right place, at the right time with a continuity of care throughout the patient journey.

A group of seven practices, covering approximately 52,000 patients, have decided to join a new model of care with our local NHS Trust, RWT. This model is called a Primary and Acute Care Model or Vertical Integration and it means that there is a collaboration between RWT and GP Practices to meet the needs of patients. This model offers practices the opportunity to contract differently, but also enables the Trust to hold certain types and this has been enabled whilst the Trust are caretakers of an APMS contract, enabling patient numbers to rise to 60,000 Wolverhampton patients.

Part of Vertical Integration is a greater level of back office support which will take care of the business element of General Practice. All staff, including the GPs of these Practices will become employees of RWT.

The majority of practices in Wolverhampton have formed three further groups. These are Primary Care Homes 1 and 2 and Medical Chambers, two groups are limited companies and the other is a group of practices working together under a memorandum of understanding that focusses on a set of principles they agree to work to. This approach enables access to services to improve whilst practices work together to share their workforce and become more resilient in the services they deliver. This means that patients may access services through practice group hubs and shared teams across practices. The introduction of care hubs will help to increase access as well as co-ordinate care so that, where possible, care can be given closer to home and in a community setting.

The CCG is committed to supporting each model of care and each practice group has their own Group Manager actively supporting both Primary Care Home(s) and the Medical Chambers groups of practices to help them further develop this new style of working.

Full Delegation

From 1 April 2017 WCCG has become fully delegated from NHSE. This means that the CCG has taken on full responsibility from NHSE for Primary Care. This includes contract management of GP Practices, contracting and assurance of how services are provided at group level as well as delivery of the Primary Care Strategy.

The CCG has been fully delegated for 12 months now and continues to work with NHSE as the accountable commissioner of Primary Care. The transition has been smooth and continues to go from strength to strength.

Performance analysis

The CCG has continued to effectively performance manage and commission local healthcare services and this work has been recognised by NHSE who awarded WCCG a 'Green Star' rating for their annual assurance assessment for 2016/17.

This excellent work has continued into 2017/18. There are quarterly checks in place by NHSE for 2017/18 for all CCG's and WCCG is once again ranked towards the top of all CCG's in the country. WCCG is working hard to maintain its 'Green Star' outstanding rating for the annual assurance assessment for 2017/18.

Our performance

WCCG's overall approach is based on:-

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

In areas where we have faced challenges to meet performance targets, we are aware of the underlying reasons and are taking action to address these. We've also put a great deal of time, energy and effort, plus some financial investment, into working with RWT to address specific areas of concern such as A&E 4 hour wait and Cancer waiting times.

Improvement & Assessment Framework

The NHS introduced the Improvement & Assessment Framework (IAF) in April 2016/17 and revised IAF guidance was published in November 2017. The latest published IAF rating is for 2016/17 and WCCG was rated Outstanding. For 2017/18 a number of updates have been made to existing indicators, a small number of indicators have been added and some indicators have been removed.

CCGs are assessed using the IAF and awarded an overall rating which is derived by the following:

- Quality of CCG leadership indicator (165a)
- Financial management
- Performance against a selection of Quality Indicators covering six vital clinical areas (cancer, dementia, maternity, mental health, learning disabilities and diabetes) which are awarded outstanding, good, requires improvement or inadequate.

End of year ratings are expected to be published by NHS England at the end of July 2018 on My NHS found at www.nhs.uk.

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

1. Cancer – 2017/18 CCG Rating: awaiting publication

WCCG and RWT are working together with NHSE, NHSI and the Cancer Alliance to implement actions to improve the cancer waits performance to meet national targets. Action plans have been refreshed and support is being made available through the cancer network:

- Plans to implement pathway redesign and service improvements to improve the one-year survival rate in line with the National Cancer Strategy
- Working with clinical colleagues and patients and carers across the cancer pathways to improve patient and carer experience
- Working with a range of partners including Public Health, Cancer Research UK and Macmillan to improve screening uptake across the City to support earlier diagnosis of cancer
- Working with clinical colleagues to improve the health & wellbeing of those diagnosed and living with cancer by delivering a range of initiatives including advice on healthy eating, exercise and much more
- Working with local GP's to deliver dedicated cancer care review appointments following the end of treatment.

2. Mental Health – 2017/18 CCG Rating: awaiting publication

WCCG has worked with the mental health provider to ensure that data flows to the MHSDS are optimal and accurate. The identified gap in provision has resulted in the commissioning of an emotional mental health and wellbeing service which will increase access rates.

The CCG has worked extensively to improve access recovery and reliable improvement rates along with IAPT waiting times and we are pleased that we have delivered to target across all these areas. Early Intervention in Psychosis access rates are very sensitive due to low numbers, but with an achievement of 100% in 7 months. We are pleased with the performance against the Eating Disorder Waiting Times and Access Standards and our strong performance against Physical Health Checks in Primary Care.

We have very few Out of Area Placements (but this cannot be zero as we have no female Psychiatric Intensive Care Unit in the Black Country) and we are working on this pro-actively.

3. Dementia – 2017/18 CCG Rating: awaiting publication

WCCG remains one of the top performing CCGs in relation to diagnosis rates for people with dementia. The aim is to sustain and improve upon the existing high standards and the CCG is working closely with Mental Health Providers, Local Authority and Primary Care Teams to support this work which includes a focus upon personalised care plans across Primary, Secondary and Tertiary care, using 'All About Me' (with the Alzheimer's Society). This work is being taken forward through our Better Care Fund Dementia Care Pathway Work Programme - a multi-agency forum that we are using as the vehicle for the delivery of the NHS England Transformation Framework - *The Well Pathway for Dementia.*

4. Diabetes – 2017/18 CCG Rating: awaiting publication

The CCG are working with local QOF/Enhanced Services groups to:

- Address QOF targets.
- To improve the number of patients who receive all 8 care processes; and
- Improve the achievement of all 3 NICE recommended treatment targets.

WCCG achieved 100% participation in the 2016/17 National Diabetes Audit (NDA) which identified issues with coding in primary care. Following this the CCG's data quality team have undertaken a review for 2017/18 activity and have provided lists of patients for practices to undertake searches and ensure coding is accurate moving forward.

WCCG has also been successful in their application as part of the National Diabetes Treatment and Care and 172 people with diabetes have attended a structured education course in 2017/18.

5. Learning Disabilities – 2017/18 CCG Rating: awaiting publication

WCCG has worked to deliver timely care and treatment reviews and embedded new services to support alternatives to admission. We have reduced the number of adult admissions, and the length of stay, although we still have high number of inpatients who are on forensic pathways (i.e. offenders). New services, including a specialist forensic health service and a new framework for forensic social care providers, are being developed with Local Authority and clinical partners.

The CCG is working with member practices to increase the offer and uptake of the Learning Disability Health check. A local improvement plan has been developed which focuses on improving GP engagement, refreshing GP training and patient and public awareness. We have also undertaken quality audits of the resulting Health Action Plans and provided feedback to the GPs.

6. Maternity – 2017/18 CCG Rating: awaiting publication

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

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

Smoking at the time of delivery - Carbon monoxide (CO) testing is offered to all pregnant women at antenatal booking appointments and active signposting, as appropriate, to a stop smoking information website. WCCG are currently awaiting sign off for a proposal to introduce a targeted smoking cessation service for pregnant women.

Still Births - In support of the national ambition to reduce the rate of stillbirths in England by 20% by 2020 and 50% by 2030, RWT have implemented all 4 elements of the Saving Babies Lives Care Bundle.

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

Women's experience of Maternity Services - The results of the 2017 CQC Maternity Survey have been reviewed with the Maternity Commissioner and Head of Midwifery. An action plan has been developed to address identified areas for improvement and progress will be monitored via the CQRM Quality & Safety Subgroup.

Performance against the key national NHS Constitution targets for 2017/18

	Target	Performance	PERFORMANCE RAG BY MONTH											
			A	M	J	J	A	S	O	N	D	J	F	M
Referral to Treatment waiting times for non-urgent consultant-led treatment														
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	92%	90.87% (ytd Feb 18)												
Zero tolerance RTT waits over 52 weeks for incomplete pathways	0	10												
Diagnostics														
Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test	99%	99.18%. (ytd Feb 18)												
A&E Waits														
Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	89.95%												
Trolley waits in A&E not longer than 12 hours	0	4												
Cancer Waits - two week waits														
Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	93%	92.63%												
Percentage of Service Users referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	93%	90.98%												
Cancer Waits - one month (31 days) waits														
Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	96%	96.75%												
Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery	94%	86.90%												
Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	99.87%												
Percentage of service Users waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy	94%	96.72%												

	Target	Performance	PERFORMANCE RAG BY MONTH											
			A	M	J	J	A	S	O	N	D	J	F	M
Cancer Waits - two month (62 days) waits														
Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer.	85%	73.62%												
Percentage of Service Users waiting no more than 62 days from referral from an NHS Screening service to first definitive treatment for all cancers	90%	82.42%												
Mixed Sex Accommodation														
Mixed sex accommodation breach (RWT & BCP)	0	2.00												
Mixed sex accommodation breach (RWT & BCP)	0	4												
Cancelled Elective Operations (RWT)														
All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice	0	0.00												
No urgent operation should be cancelled for a second time	0	0												
Health Care Acquired Infections														
Zero tolerance Methicillin-Resistant Staphylococcus Aureus	0	2.00												
Minimise rates of Clostridium Difficile	71	53.00												
Ambulance Handovers														
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	0	1,000												
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	0	162												
Mental Health														
IAPT - 75% of people engaged in the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral [Target - >75% Sanction: GC9]	75.00%	97.65%												

	Target	Performance	PERFORMANCE RAG BY MONTH											
			A	M	J	J	A	S	O	N	D	J	F	M
IAPT - 95% of people referred to the Improved Access to Psychological Therapies programme will be treated within 18 weeks of referral [Target - >95%, Sanction: GC9]	95.00%	100%												
IAPT - People who have entered treatment as a proportion of people with anxiety or depression (local prevalence)	16.80%	16.8%												
IAPT - Percentage of people who are moving to recovery of those who have completed treatment in the reporting period [Target - >50%, Sanction: GC9]	50.00%	54.32%												
Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care*	95.00%	100%												
Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis who commenced a NICE-concordant package of care within two weeks of referral	50.00%	0/2 referrals												

** Month 12 data not available at time of submission*

Summary of key performance targets

Referral to treatment (RTT) within 18 weeks

As at February performance for patients on incomplete non-emergency pathway, waiting times has seen an increase to 90.38% but has not achieved the national target as at February 2018. Primarily this remains due to capacity and demand issues and performance is being managed via a Remedial Action Plan (RAP) with the acute trust. Early indications are that March performance has achieved the 92% target, however this is un-validated at the time of reporting.

RTT Waits over 52 weeks

At the start of the year, the provider continued to manage the outstanding long waiting specialised Orthodontic service which were cleared at the end of May, and there have been no further patients waiting over 52 weeks for the remainder of 2017/18.

A&E Four Hour Waits

The national standard states that 95% of patients should be seen within four hours in an A&E department. The pressures and challenges to meeting the national target of 95% in 2017/18 in Wolverhampton are no different to that nationally. Longer length of patient hospital stays are due to more complex illnesses and patients requiring more care to ensure

that they improve or remain stable, along with medical workforce issues attributable to national recruitment challenges.

Wolverhampton performance for 2017/18 was 89.95% compared to National performance (Type 1 and Type 3) 85%, currently 34th out of 137 trusts as at the end of March.

Performance is actively monitored and managed through contract review and use of contractual levers. Local scrutiny and action planning, including targeted investment through the A&E Delivery Board is helping to ensure Wolverhampton A&E performance is ahead of others in the region. Recovery Action Plans are in place and Trust held to account for delivery, with continuous Executive oversight of both Cancer and urgent care.

Continued increase in attendance numbers during February 2018 with an additional 221 (2.21%) compared with the same period last year. However, there has been no associated increase in admissions and comparison with February 2017 shows a reduction in % of Emergency Admissions via Emergency Department (ED).

A&E 12 Hour Trolley Waits

There were four instances of A&E patients waiting in excess of 12 hours in 2017/18, all breaches were investigated and reported at the Contract Review Meeting where the appropriate contract sanctions were applied.

Cancer Waits

The Cancer Recovery Action Plan was refreshed in March and is monitored on a weekly basis including detail on key actions to support the delivery of this target.

Performance is monitored and discussed weekly via the Chief Operating Officer (COO) performance meeting, actions and milestones will be reviewed at monthly Cancer recovery plan meeting and also at the Trust's Cancer Board and at the Trust Board meeting.

Weekly conference calls discuss areas of concern and review current performance. RWT, CCG, NHS Improvement (NHSI) and NHSE all dial in to these calls which are moving to become face to face meetings. Weekly calls are being managed on a rolling cycle to discuss progress against Recovery Action Plan, Activity Forecasts and reviews of current and planned performance.

The key challenges in Wolverhampton are:

- Urology capacity; demand for robotic surgery is still outstripping availability, including referrals from Out of Area due to patients choosing to use the robot for their procedure
- Patient Choice in delaying surgery
- Late tertiary referrals; significant numbers of tertiary referrals are being received after day 42 of the patient's pathway
- Radiology capacity; increased demand has put pressure on the service to deliver reports and scans in a timely manner
- Referrals for certain specialties has increased outside of normal tolerance; Head & Neck and Breast.

Mixed Sex Accommodation

The Mixed Sex Accommodation (MSA) - locally there were two breaches reported by BCPFT which breaches relate to a Sandwell responsible female patient staying on a Penn Hospital male ward. Following MSA National guidance a single patient moving to a mixed sex ward

then means all patients on the ward are affected and are therefore in breach, therefore one breach is attributable to Wolverhampton CCG and one to Sandwell and West Birmingham CCG. An exception report was submitted by the Trust and ongoing performance monitored closely at the monthly CRM/CQRM, no further breaches were reported in the year. There were an additional two breaches for Wolverhampton patients out of area; one at Sandwell & West Birmingham Hospital NHS Trust in August and one at Medway NHS Foundation Trust in January.

Ambulance Handovers

Although ambulance handover times at The Royal Wolverhampton NHS Trust are better than at many other providers, the rise in emergency cases arriving at hospital during the winter meant handovers did not always take place within 15 minutes, and there were hour-long delays in 168 cases. This however is an improvement on performance from 2016/17.

Health Care Acquired Infections

The efforts to minimise the risks of healthcare-associated infections across Wolverhampton continues; there were two cases of MRSA at RWT during the year in October and December. A full Root Cause Analysis (RCA) was completed for both cases which were presented to the Serious Incident Scrutiny Group for review and challenge to the provider to evidence actions taken to mitigate the likelihood of recurrence, following which both incidents have been closed by the group.

As per nationally published data, there have been 50 cases of Clostridium difficile (C. diff) across all services to February 2018, with a further three in March, giving a total of 53 which is below our planned threshold of 71 in total for 2017/18. There have been 28 cases at RWT across 2017/18, which is also below the threshold set for the Trust of 35.

The CCG continues to monitor C. diff infections closely through monthly quality and safety reviews and have worked hard to tackle what is essentially a clinical issue related to underlying local health problems which has been demonstrated by the reduction in cases of C. diff compared to 2016/17.

Mental Health

IAPT - People who have entered treatment as a proportion of people with anxiety or depression

Although the Trust was reporting underperformance as at month 11; the Provider gave assurances at April CQRM that it anticipates achieving the year-end target of 16.8%.

Antibiotic Stewardship Programme

The Primary Care Medicines Team's contribution to this programme of work has been recognised in the AMR Impact Report, available via https://antibioticresistance.co.uk/home The work was based on raising awareness of antibiotics in school children and their teachers. With particular focus on four major themes:

- What antibiotic resistant bacteria is and why it is an important public health issue.
- The differences between bacteria and viruses and why antibiotics do not work on viruses.
- The importance of taking antibiotics as directed by doctors and nurses.
- The importance of hand washing for the prevention of infection.

Once again our local rates for antibiotics prescribing have exceeded the requirements set nationally.

What we've done

Joint health and wellbeing strategy

The CCG is actively involved in the delivery of Wolverhampton's Joint Health and Wellbeing Strategy, in line with our duties under section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007. The strategy is currently being refreshed to address identified local health and social care needs and will consider what the members of the Health and Wellbeing Board can do in collaboration to contribute towards the City's vision of being a thriving City of opportunity. The refreshed strategy will be published in 2018.

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

Joint Strategic Needs Assessment (JSNA)

CWC has a duty under law to provide the CCG with public health advice and commissioning support; this often takes the form of needs assessment, which is an assessment of the health needs of the population, using a variety of information such as data, local surveys, summaries of the latest research findings, and patient and public views.

CWC and the CCG are jointly required to develop a detailed assessment of current and future health and social care need. This year, we have worked together with partners to produce two specific joint Needs Assessments; Dementia and Ambulatory Care Sensitive Conditions. These will help us to commission more appropriate and effective services for the population going forward.

This year we have also worked with our partners on the Health and Wellbeing Board to publish a Pharmaceutical Needs Assessment (PNA). The PNA describes the current provision of community pharmacy services across the city and explores whether this meets the needs of our population. Production of the document has been overseen by a range of partners with an interest in community pharmacy services. It will be used by NHSE to consider future applications for new pharmacies, inform the contracting of existing services, and help to shape services in the future.

Reducing health inequalities

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

CWC and public sector partners will be working together as one to transform health outcomes across the City. In particular, we have been working very closely with our partners to bring together data from across the health and social care system, to look at patterns of health and disease in the population, which will give us better information to use when we are planning services for the future.

Joint Commissioning

The CCG has supported Public Health colleagues at CWC this year to sign up every GP practice to deliver NHS Health Checks for their patients from 2018 onwards; previously some practices have opted not to provide this service. NHS Health Checks are a quick check up to pick up risk factors for cardiovascular disease and are offered to patients aged 40-74 years who do not already have cardiovascular disease.

Practices are currently working with each other to plan how the Health Checks will be delivered, and they are exploring new ways to make the service more accessible for patients, particularly those who find it difficult to attend during work hours. They are also introducing a Point of Care testing system, which uses an fingerprick blood test to give instant results, meaning that patients will only have to attend for one appointment instead of two. Hopefully this will result in more people having an NHS Health Check, because we want more people in Wolverhampton to stay healthy and active into older age.

The CCG has also worked closely with Public Health on a Collaborative Working Model for contract monitoring in Primary Care. This allows both organisations to attend the same planned visits with GP practices to review the quality of services and assurance of contracts held with both partners. This streamlined approach has reduced the number of visits GP practices need to accommodate.

Improving the quality of services

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

- **Improving patient involvement, feedback and dignity:** we continue to work with the local community to hear their experiences of care, this assists the CCG to co-produce service changes that lead to more innovative practice and improvements in service provision. We have a wide range of support to enable us to do this, including our population of patient reviewers which has enabled patient representatives to accompany our visits and have worked closely with Healthwatch to undertake quality visits aligned to tools such as 'NHS 15 step challenge' http://webarchive.nationalarchives.gov.uk/*/http://www.institute.nhs.uk/productives/15StepsChallenge. In addition we regularly scrutinise Friends and Family test results and patient survey feedback from provider organisations and use this information as an indicator of provider service quality and to highlight areas for improvement.

- **Ensuring a system wide approach to quality assurance and safety:** We have maintained a strong emphasis on a system-wide approach to quality assurance and safety improvement through our quality and safety strategy. Our work focuses on avoiding and reducing avoidable harm in health and care and where harm has occurred, ensuring timely, transparent reporting and robust processes to ensure local and system wide learning is critical. Learning from local and national incidents and

inquiries is key to ensuring safer services for our population. Contracts with provider organisations provide a basis to drive improvement. Scrutiny of the quality of care is undertaken in a consistent way by the CCG and includes a number of quality assurance arrangements, which are used to collate and triangulate information gathered, these include formal meeting arrangements with provider organisations, announced and unannounced visits, patient and partner feedback, use of 'soft intelligence' and working in a collaborative way with regulators, including CQC, NHSE and NHSI. We also have an opportunity to share our intelligence at Quality Surveillance Group, which is a regional group convened to share best practice and escalate any particular system wide issues of concern.

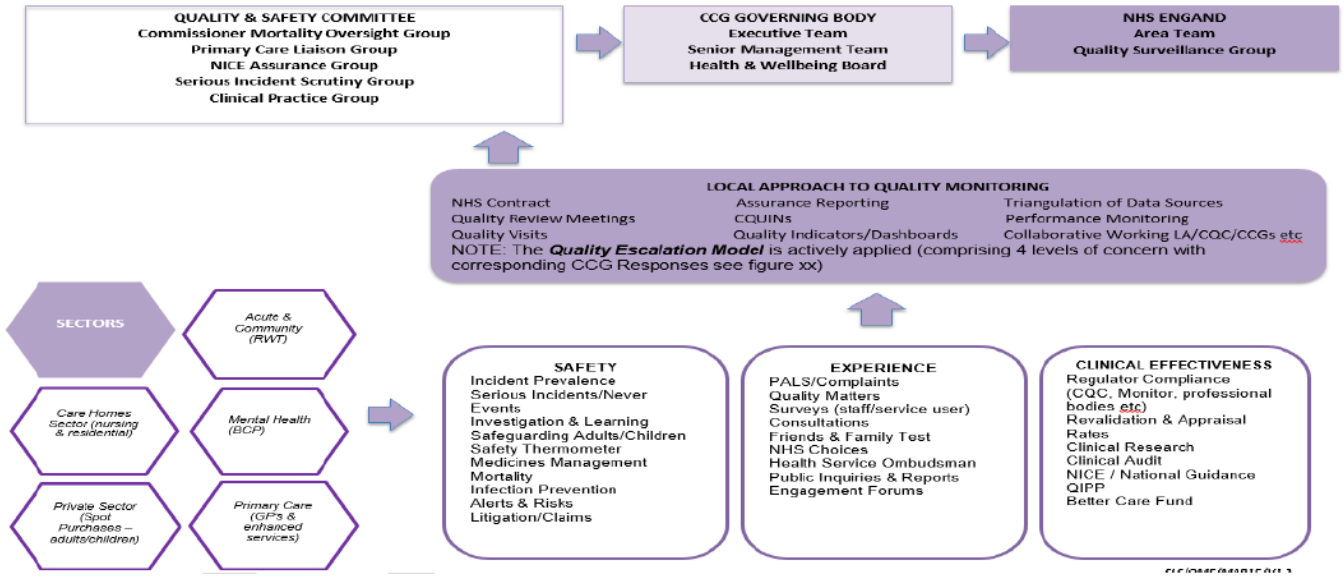
- **Ensuring Primary care services deliver safe high quality care:** Under our delegated commissioning responsibilities we have strengthened and developed processes for assurance and development. We are working in collaboration with Primary care colleagues to ensure robust reporting systems, timely responses to issues and ensuring appropriate action and learning should incidents occur.

- **Commissioning and delivering services that are compliant with National Institute for Health and Care Excellence (NICE) guidance and quality standards:** improvements in medicine and treatment are made available to patients in line with national guidance. This enables the most up to date and effective care and treatment to be provided to treat the conditions our patients are experiencing. A monthly NICE Assurance Group meeting is held with our providers in order to provide the CCG with assurances regarding the implementation of NICE guidance. To ensure medications are prescribed in line with NICE we have commissioned the use of BlueTeq which provides us with assurance that patients are being offered the most appropriate treatments in line with NICE TAGs. It also provides us with assurances patients being treated with NICE approved treatments are being routinely reviewed in line with recommendations. Our providers are asked to present us with evidence through audits to show compliance with NICE guidance. Within primary care, we have commissioned a team of pharmacists and technicians to run audits to ascertain how our primary care prescribing measures against NICE guidance and quality standards.

- **Safeguarding**: The safeguarding team ensures WCCG is able to demonstrate that they have appropriate systems in place for discharging their statutory duties in term of safeguarding. On behalf of WCCG the safeguarding team seek assurances from the organisations from which they commission services that they have effective safeguarding arrangements in place. WCCG work collaboratively with all partner agencies to ensure critical services are in place to respond to children and adults who are at risk or who have been harmed, in order to deliver improved outcomes and life chances for the most vulnerable.

Our Care Homes Improvement Plan: Is moving at pace through the Promoting Safer Provision of Care for Elderly Residents (PROSPER) and now in its transition the next phase, Safer Provision & Care Excellence (SPACE). The aim of the programme is to train staff and managers in service improvement techniques, with the aim of strengthening the safety culture and reducing adverse events. Embedding this across Wolverhampton is the legacy that will incorporate our 'sign up to safety' pledges.

Quality governance structure



Patient safety

We continue to monitor serious incidents that arise involving our patients. This is now done through Scrutiny Groups that include our Providers of healthcare services, to encourage an open dialogue. In the spirit of openness and transparency a fluid conversation takes place regarding all root cause analyses. This enables us and our health care services to identify learning opportunities and be assured that care in those settings has been investigated to identify what went wrong and what action is required to prevent further occurrences. We strive to ensure that the care provided to our patients is as safe as possible. We have seen two 'Never Events' reported this year and continue to work with our providers to ensure sufficient controls are in place to prevent further incidents of this type occurring again in the future. This has formed a structured programme of quality visits, both announced and unannounced, and table top reviews that have included national regulators/organisations.

Developing mental health services

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

We have a number of deliverables in line with the Five Year Forward View for Mental Health and are working with our partners across health and social care to develop and deliver our commissioning plans to deliver Five Year Forward View for Mental Health locally.

There are some key priorities which are concerning:

- improving access to evidence based care
- maintaining the mental health investment standard
- improving data reporting including against new key mental health key performance indicators and standards
- improving integration with mental and physical health services to improve the physical health of people with mental health difficulties including people with severe and enduring mental illness

For our Black Country and West Birmingham region we are hosting Thrive, which is a project working with the West Midlands Combined Authority that supports people with mental and /

or physical health difficulties into paid employment or self-employment. This involves a research trial and is a programme of national significance. We are very proud to be supporting this project on behalf of our region.

Again for our Black Country and West Birmingham region we are delivering a Perinatal Mental Health work programme – this is to cover a gap in access to specialist care across our footprint. We have applied for transformation funding and have invested some funds in setting up new services, such as specialist clinics in maternity units for new and expectant mums.

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

We have commissioned a primary care mental health counselling pilot as part of our plans to improve primary care support for people with mental health difficulties. We will build on this in 18/19 as we develop IAPT services to improve our care pathway to older people from Black and Minority Ethnic Groups, people with long term conditions and people with perinatal mental health conditions.

We have also invested in a refugee and migrant Community Psychiatric Nurse to support new arrivals into our city.

This is in addition to our on-going work to improve clinical outcomes, particularly for people with continuing and longer-term needs.

We have continued to develop urgent and planned mental health care pathways as part of our Better Care Fund programme integration. This work will be aligned with the Wolverhampton Crisis Concordat and is part of our programme of work to develop NICE concordant care in terms of Mental Health Liaison and Crisis Resolution Home Treatment specifically. In line with this we have also implemented new access and waiting time standards for our Eating Disorder and Early Intervention in Psychosis Services.

Also, as part of our Better Care Fund programme integration we have worked with our partners to re-design Dementia Care Pathways. We will move forward with this work into 18/19 as a key priority and will build on the Dementia JSNA to develop and inform our Dementia Strategy refresh. The focus will be upon preventing well, diagnosing well and living well, continuing to improve our diagnosis rates and our access to primary and community care plans for people with dementia and their carers, and ensuring that access to treatment and care and support meets waiting times and access standards.

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

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

Child and Adolescent Mental Health

This year we have refreshed our Child and Adolescent Mental Health (CAMH) Transformation Plan 2017-2020 to give a clear description of the transformational work that

has taken place to date, and what the intentions are regarding the investment the CCG is to receive to ensure we are able to meet the needs of our young people.

The original plan identified a gap in provision at an early intervention and prevention stage for children and young people with emotional mental health and wellbeing needs and as a result, WCCG is jointly procuring an Emotional Mental Health and Wellbeing service with CWC and HeadStart, as well as procuring an online counselling service to meet the needs of young people. These services will be available during April/May 2018.

Further work is planned to re-specify some of the more specialist services to ensure that there is the correct level of support, as and when a child or young person requires it. Work is also being undertaken with CWC around the all age Autism strategy, which includes the diagnostic pathway to ensure that there are clear pathways available for Children and Young people to be diagnosed in a timely manner, as well as signposting to appropriate support and interventions.

Digital transformation journey

WCCG has pursued a strategy to identify and adopt new technologies. We were the first CCG to implement free NHS patient Wi-Fi last year and were one of the first CCG's to implement GP Remote Consultation for GP Practice groups, which supports extended opening hours and the ability of Clinicians to hold and record consultations with patient's from any of the practices within the federated GP Groups.

For the coming year we have a large portfolio of work. These include the provision of a texting solution that increases the range of texts that we can send to patients while allowing patients to cancel appointments by text.

We have started an ambitious project to migrate to Windows 10 from Windows 7; we aim to migrate to the new operating system over the next 18 months, ensuring that the migration is complete before Windows 7 goes end of life on 14 January 2020.

We have continued to develop the Wolverhampton Shared Care Record and have now started working with Walsall to identify synergies and ways that we can bring our systems together to create a combined Wolverhampton and Walsall shared care record.

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

Service changes this year

2017/18 has been another busy year in regard to procurement activity within the CCG, ably supported by Arden and GEM CSU. During the course of the year the CCG has renewed its Procurement Policy to incorporate changes to national regulations. It has also undertaken a number of procurement projects, with a summary of these as follows:

Community Eye Services

The CCG originally commissioned Community Eye Care Services in August 2014 following an Any Qualified Provider (AQP) procurement. The contract was due to expire in 2017 and consequently a further AQP procurement process was conducted. Only one bid was received and that was from the incumbent service provider Heart of West Midlands Primary Eyecare Ltd, who are a consortium of local optometrists. The Governing Body approved for a new contract to be put in place from 1 September 2017.

Thrive Into Work (Individual Placement Support)

In July 2017, the CCG formally entered into a partnership arrangement with the West Midlands Combined Authority to host a programme of work known as Thrive into Work - Individual Placement Support (IPS).

This is an exciting project funded by a cross government department Work and Health consortium which aims to deliver a transformational improvement in employment, health, and wellbeing outcomes for people who are out of work with a self-defined long term health condition or disability. This aim will be achieved by deploying employment specialists across primary and community NHS services focused on four geographic areas based around CCG geographies: Wolverhampton, Sandwell and West Birmingham, Birmingham and South Central, and Dudley.

In its role as the host organisation, WCCG took on responsibility as the contracting authority for the programme and part of that responsibility included conducting a procurement process to select appropriate specialist providers. This commenced in June 2017 and the evaluation process concluded on 18 August. There was a clear outcome across the four geographical lot areas as follows:

- Lot 1 – Wolverhampton: Remploy Limited
- Lot 2 – Dudley: Dudley and Walsall Mental Health Partnership NHS Trust
- Lot 3 – Sandwell & West Birmingham: Prospects Services
- Lot 4 – Birmingham South Central: Remploy Limited

A lot of work has been taking place since to mobilise the service and the programme is due to be officially launched to the public on 26 March 2018.

Continuing Healthcare – Care Home Framework

This provides an opportunity for local care homes to apply to be part the CCG's framework, which gives a guaranteed price in return for delivery of a service which adheres to a robust specification with defined quality standards. In utilising the Any Qualified Provider (AQP) mechanism, there is no guarantee of activity to providers and therefore they are zero value contracts. Selection is largely determined by patient choice. This is the third time this has been advertised to potential providers in the past two years. The evaluation process took place and there was one successful bidder – Newlyn Court. This home will be added to the framework as from 1 April 2018.

Primary Care Medicines Optimisation Support Service

The Primary Care Medicines Optimisation and Support Service has been provided by RWT for the past five years. It was procured due to the contract expiring (including two extended years) and due to value exceeding the European Union threshold. The tender evaluation process completed in November 2017 and an award report went to the December Governing Body for consideration. A decision was made to cancel the procurement and a notification was posted to the final bidders which included the following statement:

Since this procurement began in May 2017 the NHS landscape has changed significantly to the point where the CCG needs to relook at all services and consider its evolution to an Accountable Care System model. As this change is so significant for the CCG, it needs to look at each and every service it commissions and how they can be integrated etc. At this point in time, we believe it to be in the best interests of the CCG to cancel this procurement whilst it takes stock of its position and considers how best to move forward.

An interim contract extension is being put in place with RWT for a 12 month period up to March 2019. A full evaluation of the service will take place within the next six months to determine the best commissioning option for this service in the future.

Primary Care Counselling Service

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

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

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

Engaging people and communities

Commissioning Intentions

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

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

We held four public events spread over three consecutive days. We completed surveys with over 300 members of the public during the events. Topics discussed included:

- Range and views of health care services used within the last twelve months
- Awareness of services that are currently provided in a community setting
- Enquiry about willingness to see professionals (other than a GP) in a GP surgery setting
- Views on where health care services should and could be provided
- Request on what and who respondents rely on for advice and help with healthcare issues.

We have shared these results in the form of a ‘You said – We did’ document available on WCCG website. https://wolverhamptonccg.nhs.uk/contact-us/you-said-we-did

Feedback mechanisms

We receive concerns, compliments and comments via our many communication channels; these are then fed back to our Quality and Safety and Commissioning teams in the CCG.

These channels are our website, local media and social media. It is also via these outlets that we inform the public about the outcomes of our engagement work and how public and patient views have informed our decisions. Our Lay Member for Public and Patient Involvement represents public and patient views at our Governing Body meetings, and ensures that we are fulfilling our obligations in relation to engagement and consultation.

Listening and acting upon the feedback that patients and the public have taken time and effort to share is very important to us. Some of the information patients have given to us has been used to influence our commissioning as part of the Commissioning Engagement Cycle. When we met with people in 2017, they told us the following:

Patients' said that they wanted better access to GP surgeries.

- People go to A&E department or Walk in Centre because they can't get appointments with their GP
- Walk in Centres and GPs can be improved with better access
- It is frustrating to have to call the GP for an appointment in the morning only to be told there is none

We did in response:

During the winter period, Wolverhampton practices helped to ease pressures by offering more GP appointments from December to March. Practices worked together to ensure a number of primary care hubs were open during the Christmas and New Year period. This enabled patients from a range of different practices across the city to access healthcare on a bank holiday within a hub rather than going through the urgent care system. This work has continued at Easter, spring and summer bank holidays and on Saturday mornings. Patient feedback has been excellent and people have really appreciated the opportunity of being seen closer to home in their own communities.

We have encouraged patients to sign up to use online services to book appointments. Patients have found that the ease of using the online services has greatly benefitted them and it is often commented on that the availability and convenience of online services is one of the things they highly value about their GP practice.

Public and stakeholder involvement groups

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

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

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

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

Annual General Meeting (AGM)

On Wednesday 26 July we held our AGM. Over 100 members of the public attended, including representative of partners from local groups and other organisations, as well as clinicians, our staff and local stakeholders.

The event included a presentation about what the CCG has achieved in the last 12 months and the challenges the CCG faces in the future. The event showcased the CCG's strong achievements over the last 12 months including improvements that have been made to GP services and the opportunity for us to announce our 'Outstanding' rating from NHSE. We are one of only four CCG's in the country to have received the rating two years in a row.

We began with a demonstration of 'Extend', a gentle exercise regime, led and demonstrated by a local 'Extend' teacher. We then showcased our work via four videos on Patient Online, TWIRL (a social group for our patients living with COPD), quality in End of Life care and an animation gameshow highlighting the importance of choosing the right service.

Questions were posed to our senior management team. The transcript from the full question and answer session is available on our website. www.wolverhamptonccg.nhs.uk/news/499-agm-2017-success

Campaigns

Winter - This campaign, which was an output of the Wolverhampton A&E Delivery Board, started in October 2017 and completed mid-April 2018. It had a dual focus of encouraging our target audiences to stay well, and to choose appropriately when in need of urgent or emergency care. The objective was to reach out to, and educate groups with a higher propensity to present inappropriately at urgent and emergency care services.

This year also we joined across our STP footprint in the Black Country and West Birmingham to deliver joint messages via social media and press.

Phase one from October 2017 focused on promotion of uptake of the flu vaccine to the nationally defined target groups. One of the promotion methods was to share videos of local people and clinicians receiving the flu jab. The videos can be viewed here https://www.youtube.com/channel/UCsQ_6HZDhmS459XfDS5Dk8Q

Phase two focused on winter preparedness and wellness using the Stay Well branding, but the primary objective was to communicate and engage on NHS 111, Self Care and pharmacy to the targeted audiences. We used a variety of methods of delivery including outreach targeting community groups, online, face to face engagement on the street, local supermarkets and in local Gyms.

A report outlining activity, measured outcomes and recommendations will be submitted to the A&E Delivery Board later on this year.

Dr Helen Hibbs
Accountable Officer
22 May 2018

ACCOUNTABILITY REPORT

Members report

Our member practices

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

Bilston Urban Village Medical Centre BRANCH Bilston Health Centre	Wolverhampton WV14 0EE
Intrahealth Pennfields Medical Centre	Upper Zoar Street, Pennfields Wolverhampton, WV3 0JH
Dr Jackson and Partners Tettenhall Medical Practice BRANCH Wood Road	Lower Street Tettenhall Wolverhampton, WV6 9LL
Dr Jones and Partners Woden Road Surgery	Woden Road, Tettenhall Wood Wolverhampton, WV6 8NF
Dr M Kainth Primrose Lane Health Centre	Primrose Lane, Low Hill Wolverhampton, WV2 3BT
Drs M Kehler and Naz Keats Grove Surgery	7 Keats Grove, The Scotlands Wolverhampton, WV10 8RN
Dr R Kharwadkar Fordhouses Medical Centre BRANCH Pendeford Health Centre	68 Marsh Lane, Fordhouses Woverhampton, WV10 8LY
Dr K Krishan and Partners Mayfields Medical Centre BRANCH Cromwell Road Surgery	272 Willenhall Road Wolverhampton, WV1 2GZ
Drs C Lal and New Bradley Medical Centre	83-84 Hall Green Street, Bradley Wolverhampton, WV14 8TH
Drs Libberton and Ram	60 Cannock Road Wednesfield, WV10 8PJ
Dr G Mahay Poplars Medical Practice	122 Third Avenue, Low Hill Wolverhampton, WV10 9PG
Dr Mittal Probert Road Surgery	Probert Road, Oxley Wolverhampton, WV10 6UF
Dr J Morgans and Partners Prestbury Medical Practice BRANCH Hellier Road, Bushbury	81 Prestwood Road West Wednesfield, WV11 1HT
Drs N Mudigonda and Mudigonda Bilston Health Centre	Prouds Lane, Bilston Wolverhampton, WV14 6PW
Dr J Parkes and Partners Alfred Squire Road Health Centre	Alfred Squire Road Wednesfield, WV11 1XU
Parkfields Wolverhampton Medical Services Ltd Ettingshall Medical Centre	Herbert Street, Ettingshall Wolverhampton, WV14 0NF

Dr G Pickavance and Partners The Newbridge Surgery	255 Tettenhall Road Wolverhampton, WV6 0DE
Dr S Ravindran and Majid East Park Medical Centre	Jonesfield Cresent, East Park Wolverhampton WV1 2LW
Dr H Richardson and Partners Thornley Street Surgery	40 Thornley Street, Wolverhampton, WV1 1JP
Drs Saini and Mehta	62-64 Church Street, Bilston Wolverhampton, WV14 0AX
Dr M Sidhu and Partners Lea Road Medical Practice	35 Lea Road, Pennfields Wolverhampton, WV3 0LS
Dr A Sharma Bilston Health Centre	Prouds Lane, Bilston Wolverhampton, WV14 6PW
Dr S Suryani The Surgery	Hill Street, Bradley Wolverhampton WV14 8SE
Dr K Sidhu and Partner West Park Practice	Park Road West, Tettenhall, Wolverhampton, WV1 4TF
Dr P Venkataramanan and Partners Grove Medical Centre BRANCHES Caerleon Surgery, Dover Street All Saints & Rosevillas, 17 Cartwright St All Saints & Rosevillas, 1 Shale Street	175 Steelhouse Lane Wolverhampton, WV2 2AU
Dr Vij and Partners Whitmore Reans Health Centre BRANCHES Pendeford Health Centre Ednam Road Surgery	Lowe Street, Whitmore Reans Wolverhampton, WV6 0QL
Dr Wagstaff and Partners Castlecroft Medical Practice	Castlecroft Avenue Wolverhampton WV3 8JN
Dr Whitehouse	The Surgery, 199 Tettenhall Road Wolverhampton, WV6 0DD
Drs Williams, De Rosa and Koodaruth Warstones Health Centre	Pinfold Grove, Warstones Wolverhampton, WV4 4PS
Wolverhampton Doctors Ltd Showell Park	Fifth Avenue Wolverhampton, WV10 0HP

Composition of Governing Body

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

During 2017/18 we have altered the structure of our Governing Body to include representation from the GP Groups operating in Wolverhampton. Elections were held in October for a Clinical Chair (elected across all practices) and six other GPs to represent the groups. Following the election, the members of the Governing Body were:

Chair – Dr Salma Reehana

Accountable Officer – Dr Helen Hibbs

Other elected GP members:

Representing 'Unity' (Medical Chambers Group)

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

Representing Primary Care Home 1 Group

- Dr Mohammad Asghar

Representing Primary Care Home 2 Group

- Dr Rashi Gulati

Representing Vertical Integration Group

- Dr Julian Parkes

Chief Finance Officer – Tony Gallagher

Director of Strategy and Transformation – Steven Marshall

Chief Nurse – Sally Roberts

Director of Operations – Mike Hastings

Lay Member for Audit and Governance – Peter Price

Lay Member for Finance and Performance – Les Trigg

Lay Member for Public and Patient Involvement – Sue McKie

Practice Manager Representative – Helen Ryan

Secondary Care Consultant – Amarbaj Chandock

Co-opted Deputy Chair - Jim Oatridge OBE

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

Prior to the Governing Body Election, Jim Oatridge acted as interim Chair from April 2017 until November 2017 and he has agreed to remain on the Governing Body on a Co-opted basis to support Dr Reehana in the transition into the role of Chair.

During the year, a number of Governing Members have moved on from the CCG:-

Claire Skidmore, Chief Finance and Operating Officer left in June 2017 to take up the role as Chief Finance Officer at Shropshire CCG. Claire joined the CCG from Wolverhampton City PCT when the CCG was authorised and played a key role in establishing and maintaining the CCG's sound financial management systems that have underpinned our success.

Manjeet Garcha, Executive Lead for Nursing and Quality retired in October 2017, having led the quality agenda at the CCG since establishment. Manjeet has had a long and distinguished career across the NHS and the Governing Body joined staff at the CCG in wishing her well in her retirement.

Pat Roberts, Lay Member for Patient and Public Involvement stepped down from her role in September 2017. Pat has also served the CCG since it was established and has been a tireless champion for patient involvement both within the CCG and across Wolverhampton for many years and CCG staff, Governing Body members and patients joined to thank Pat at an event in September.

Dr Julian Morgans left the Governing Body following the elections in October. Dr Morgans has served on the Governing Body since the CCG was established, making significant contributions to a number of key agendas including urgent and emergency care and serving as chair of the Commissioning Committee for the past two years. Dr Morgans is continuing to support the work of the CCG on urgent and emergency call and the NHS Rightcare agenda.

Audit and Governance Committee members

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

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

Peter Price acted as chair of the Committee on an interim basis whilst Jim Oatridge Chaired the Governing Body and was confirmed in post on a permanent basis in November 2017.

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

Governing Body register of interests

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

Personal data-related incidents

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

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

Statement as to disclosure to auditors

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

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

Member engagement

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

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

Our quarterly Members meetings provide an opportunity for member practices to contribute to the developing clinical priorities across the City. During the year topics have included a discussion on Multispeciality Community Provider approaches, outline priorities for a new Outcomes Framework for General Practice and contributions to national consultations on prescribing in Primary Care. We continue to use a range of strategies to communicate with practices including updating by email, e-newsletter and through our intranet.

Since taking on fully delegated responsibility for the commissioning of Primary Care, we have aligned our practice support visits to provide a collaborative approach to contract and performance monitoring involving colleagues from Local Authority public health. This approach has been welcomed by practices and we are working closely with them to refine the process to ensure the visits are a productive and valuable source of information and practices are not required to produce similar information multiple times. Practices are also working in their groups to discuss best practice on referrals into secondary care. Meanwhile, our nationally recognised Quality Matters reporting site is used by member practices to share healthcare experiences with the quality and risk team.

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

Modern Slavery Act

WCCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. The CCG's statement on modern slavery can be found here: https://wolverhamptonccg.nhs.uk/publications/safeguarding-1/2310-modern-slavery-statement.

Statement of Accountable Officers responsibilities

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

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

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money,
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)),
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,
- Prepare the financial statements on a going concern basis.

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

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that

I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.

- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable

Dr Helen Hibbs

Accountable Officer

22 May 2018

Governance Statement

Introduction and context

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

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

As at 1 April 2017, the clinical commissioning group is not subject to any directions from NHSE issued under Section 14Z21 of the National Health Service Act 2006. We have made significant progress as an organisation since we were established, developing a strong record of accomplishment of delivery of our statutory responsibilities and strategic objectives. We have grown as an organisation to take on additional responsibilities for the commissioning of Primary Medical services, which has developed our capacity to work much more closely with our GP membership. This is enabling us to become a key system leader in the development of improved and integrated health and social care, primarily in Wolverhampton but also across the wider Black Country through our work on the STP. Much of this is underpinned by the development that has been undertaken in our financial management and systems of internal control that are described in this Governance Statement.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

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

Governance arrangements and effectiveness

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

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

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

These include:

a) the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;

b) The Good Governance Standard for Public Services;

c) the standards of behaviour published by the Committee on Standards in Public Life (1995) known as the 'Nolan Principles'

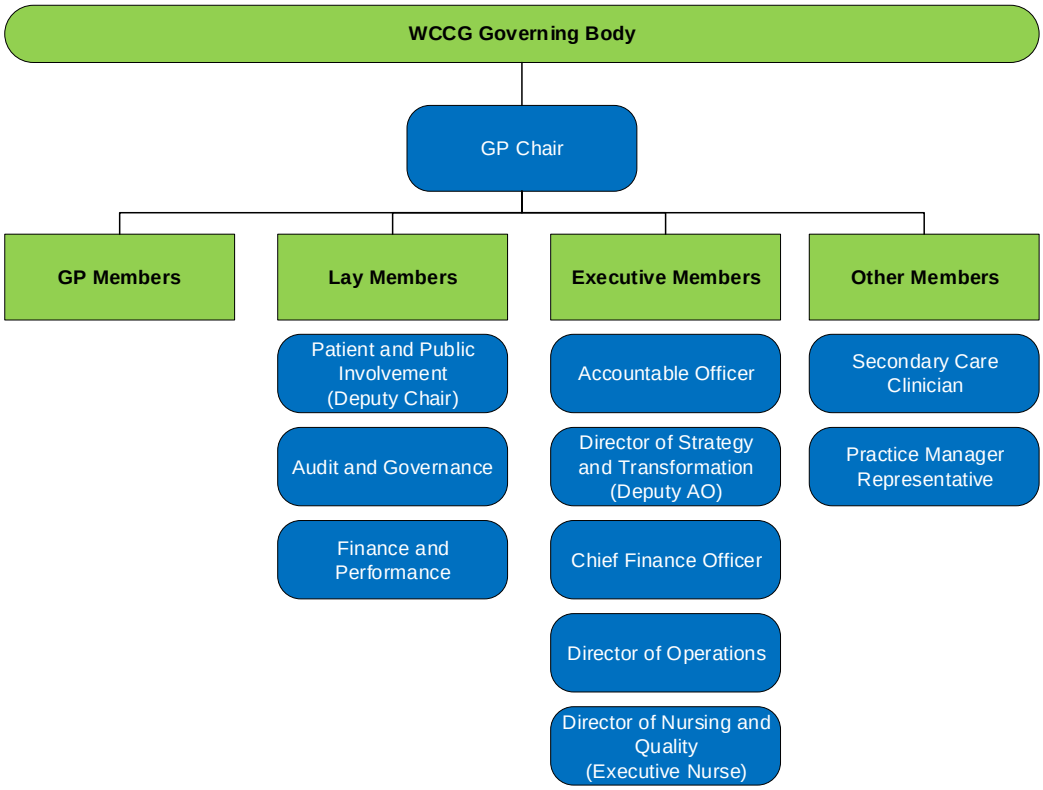
d) the seven key principles of the NHS Constitution;

e) the Equality Act 2010."

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

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

Our membership is currently constituted of 43 practices across Wolverhampton. The Governing Body acting on their behalf includes seven elected GP Members including the Chair, Executive Members, Lay members, Practice Manager and Secondary Care Specialist. In total, the Governing Body consists of 17 members, of which five are executive and 12 are non-executive. The structure is shown below:



[1] - *Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, and Leadership.*

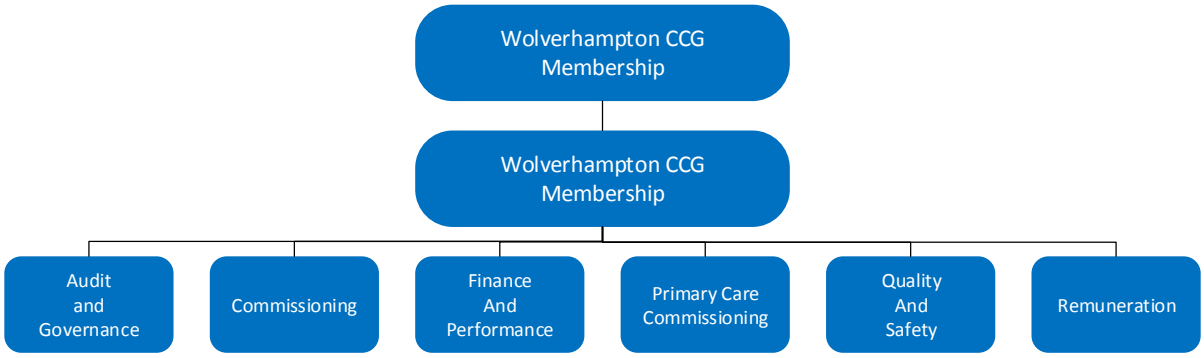
In addition, non-voting Observers from the Local Medical Council, City Council, Health and Wellbeing Board and Local Healthwatch also routinely attend Governing Body meetings. The structure of the elected GP members of the Governing Body has changed during the year to reflect the emerging GP groupings in Wolverhampton that are developing new models of care in line with the Forward View. This also involved the election of a new clinical chair. Further detail on these changes, the make-up of the Governing Body and attendance rates at Governing Body meetings can be found in the membership report in the CCG's Annual Report.

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

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

Both clinical and non-clinical members of the Governing Body sit on each of the committees, which also have additional members from within the CCG and from other organisations (the clinical members of the Primary Care Commissioning Committee are non-voting). Each committee has an agreed Terms of Reference and established membership which are set out in the group's constitution which is published on the CCG website.

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



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

The **Audit and Governance Committee,** as highlighted later in this statement, has a key role in the Group's risk management strategy. During the year it has fulfilled this role by maintaining an overview of the development of the Clinical Commissioning Group's risk register and Governing Body Assurance Framework (GBAF). It has also continued to support the development of the CCG's governance framework, including developing policy around Managing Conflicts of Interest in line with new national guidance. The Committee has also received reports on compliance with the UK Corporate Governance Code as a

[2] The Primary Care Commissioning Committee exercises the powers delegated to the CCG from NHS England in respect of Primary Medical Services. The CCG has not delegated any additional powers to the committee.

reference point for good practice. In support of the CCG's work to collaborate with other partner CCGs in the Black Country STP the Committee has worked with its equivalent committees in Dudley, Walsall and Sandwell and West Birmingham to establish an advisory group to consider the audit arrangements for proposals for joint commissioning.

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

The **Finance and Performance Committee** has provided the Governing Body with assurance around action taken to address identified issues and underlying risks relating to the group's finance position as well as the assurance provided to NHS England that the Group has met its financial planning requirements. It has also maintained an overview of performance against relevant targets (including NHS constitutional standards) and action taken to address issues. In support of this work, the committee considered details of an internal audit of the CCG's approach to assuring data quality and the associated actions. The Committee is also responsible for monitoring the Group's performance against its statutory duty to reduce inequalities and has received assurance on work to achieve this.

The **Primary Care Commissioning Committee** exercises the functions delegated to the CCG on behalf of NHS England in relation to the commissioning of Primary Medical Services. During the year, this has included making decisions on requests for practices to merge, sub-contracting their services and closing branch surgeries. In line with national statutory guidance on managing conflicts of interest, the Committee has a Lay Chair, a non-clinical majority and the GP members do not have voting rights.

The **Quality and Safety Committee** provides the Governing Body with assurance that the services commissioned by the group are of high quality and promote a culture of continuous improvement. It also maintains, on behalf of the Governing an overview of a number of significant and potentially high risk issues, including Safeguarding and Information Governance. Where necessary, it has escalated issues for consideration by the Governing Body and provided assurance on action taking place.

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

UK Corporate Governance Code

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

For the financial year ended 31 March 2018, and up to the date of signing this statement, we complied with the relevant provisions set out in the Code, and applied the principles of the Code. Steps have been taken during the year to address minor issues identified through the Audit Committee's review process, these are detailed throughout the statement.

Discharge of Statutory Functions

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

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties. In addition, as part of the programme of work supporting greater collaborative commissioning across the STP footprint the Governing Body has considered and endorsed an approach that recognises that any delegation of commissioning responsibilities will need to be supported by appropriate assurance to the CCG that statutory duties are being discharged.

Risk management arrangements and effectiveness

The Clinical Commissioning Group has put in place a comprehensive structure of controls to co-ordinate and manage risk within the organisation. This consists of lines of accountability through which issues of risk can be discussed and the effectiveness of our risk management arrangements assured.

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

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

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

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

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

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

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

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

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

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

Acceptable Risks

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

Moderate Risks

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

Unacceptable Risks

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

Significant Unacceptable Risks

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

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

framework. As reported in our 2016/17 Governance Statement, we have taken steps to address weaknesses identified by our internal auditors in our risk management arrangements as follows:-

- The realigned GBAF has been used by the Governing Body to analyse the overall risks to the organisation achieving its strategic objectives, supported by oversight of the key corporate risks impacting on these objectives.
- Each of the Governing Body committees has been developing its own risk profile by scrutinising risks relating to their area of responsibility, identifying and escalating strategic risks to the Governing Body that have an impact on the GBAF. This provides the Governing Body with assurance that risks are being effectively managed and scrutinised at the appropriate level within the organisation.
- Executive responsibility for risk management has been allocated to the Director of Operations and additional resource has been allocated within the Operations Directorate to support the development and implementation of a refreshed Risk Management Strategy. The Corporate Operations Manager is now the lead for risk management within the organisation, providing clear synergies with other elements of the CCG's Corporate Governance Framework.

The steps taken by the CCG have resulted in significant improvements to address the identified previous weaknesses. The CCG is committed to continuous improvement and development to ensure that effective arrangements are fully embedded throughout the organisation.

Capacity to handle risk

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

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

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

The CCG cannot manage its risks effectively unless it knows what the risks are. All directors and heads of service are responsible for ensuring their teams are briefed on the policy and that the processes contained within it are actively implemented and embedded. Therefore, all teams will hold a risk profile and maintain a team risk register to encompass all risks the service faces. Risks identified at this level will be assessed against team objectives in the first instance.

Where teams consider that risks they have identified need to be brought to the attention of the appropriate Committee they inform the Corporate Operations Manager who arranges for the risk to be added to the Committee Risk Register. The Committee then assesses the risk to determine the assessment at team level remains appropriate when assessed against broader organisational objectives. Once the Committee has considered the risk it will ensure that the risk is appropriately reviewed and, if necessary, escalated to the Governing Body for

further attention and assessment if required. The Operations Team are responsible for developing a programme of training and support on how teams effectively identify and manage risks. Emphasis is placed upon understanding the level at which a risk needs to be managed and, the objectives that the risk impacts on. For risks managed at Committee or Governing Body level all risks are aligned to their impact on the Clinical Commissioning Group's Governing Body Assurance Framework, to enable the responsible committees and Governing Body to regularly review the influencing factors from new risks and their impact on the control measures for the respective assurance framework domain(s). One of the domains within the Governing Body Assurance Framework is the CCG continuing to meet its statutory duties and responsibilities, enabling the CCG to assess the risk of the CCG not meeting its statutory obligations in a timely manner.

Risk Assessment

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

Red risks that are currently open at the end of the year that have implications for governance are as follows:-

- **Failure to achieve long term financial strategy –** Recurrent financial pressures may make it difficult to deliver the CCG's financial plans for future years. The Finance and Performance Committee have identified that, in common with many NHS organisations, the CCG faces on-going financial challenges in the medium to long term. Mitigations are in place to deal with this, in particular robust financial planning and the proactive approach to the identification and delivery of the CCG's QIPP programme of work.

Other sources of assurance

Internal Control Framework

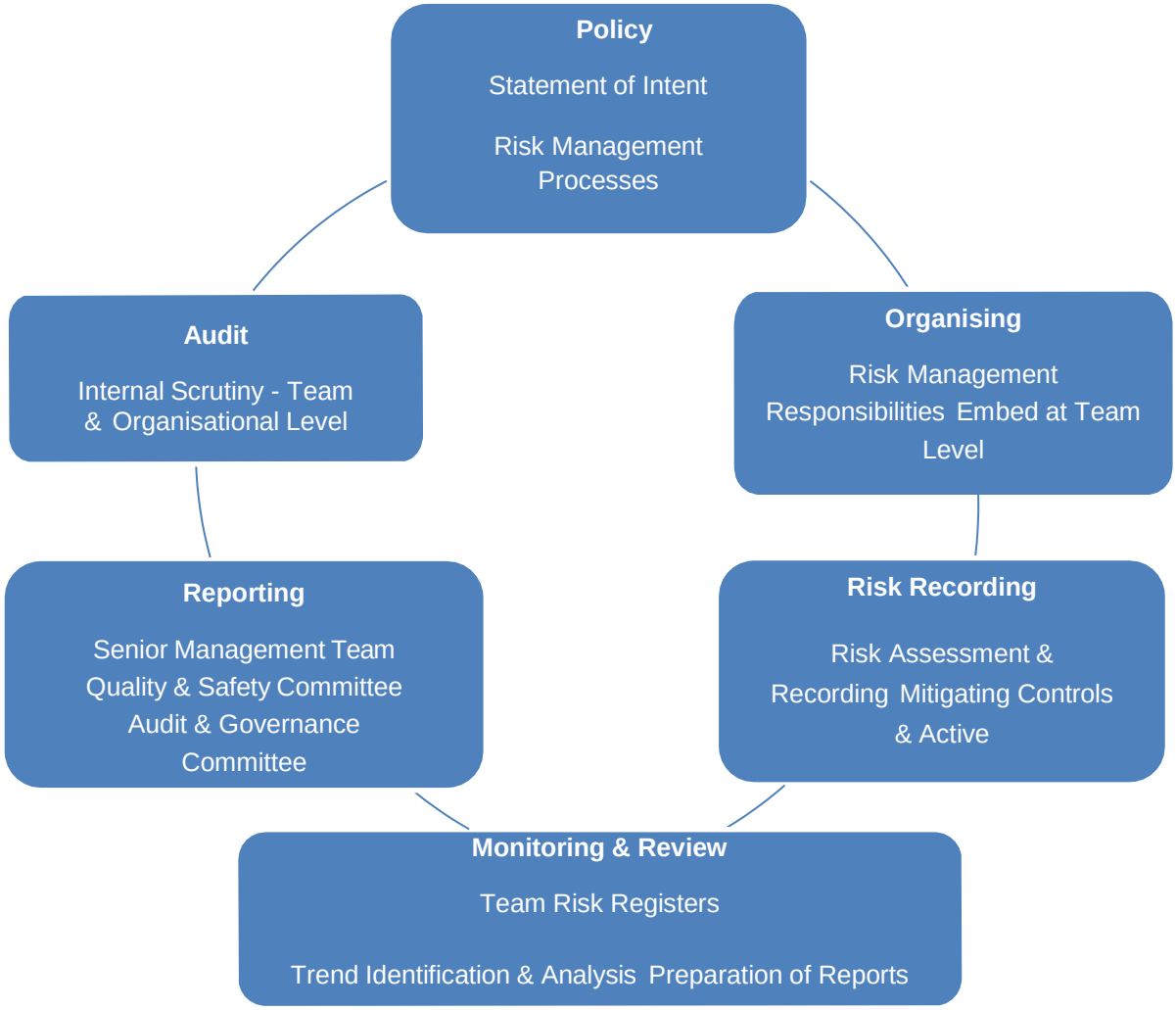
A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should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

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

The Clinical Commissioning Group has a set of processes and procedures in place to ensure it delivers its policies, aims and objectives and this is audited internally. It is designed to identify and prioritise risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The CCG's system of internal control has been supported by using an electronic database supplied by a nationally recognised risk management specialist, Datix. During the year the changes to risk management have seen some of the key processes moving away from using Datix support and consideration is being given to working in a more flexible manner. As highlighted above, this is based on the principles outlined in the risk management framework which clearly articulates the relevant roles and responsibilities of key individuals and teams

as well as the overall corporate responsibilities of all staff. These overall arrangements are summarised in the diagram below:-



Annual audit of conflicts of interest management

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

The CCG's internal audit review of conflict of interest management followed the national template and also focussed on the CCG's response to revised statutory guidance from NHS England and a review of the implementation of our prior year findings. The changes to the guidance covered registers of interests, gifts and hospitality, sponsorship and new care models and the internal audit review raised two current year findings (one low risk and one advisory), recommending that the most up-to-date version of the CCG's policies are made available online and that the CCG considers how its Conflicts of Interest policies reflect NHSE's guidance on New Care Models. Both of these recommendations have been agreed and are being actioned. The review of prior year recommendations relating to raising awareness of conflicts of interest, the timely receipt of staff declaration of interest forms, the completeness of the Register of Interests and Gifts and Hospitality Register and the need to document declarations and management of conflicts of interest in contract management meetings found that each of these recommendations have been implemented.

Data Quality

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

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

The underlining principles to our data quality are as follows;

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

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

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

The robustness of our data security arrangements was demonstrated in a live environment during the ‘Wannacry’ Cyber Attack in May 2017. Working with our IT Service Provider, Royal Wolverhampton Trust, the CCG determined that no networks across the CCG, GP Practices or RWT were affected when the virus was initially reported. Further work took place to ensure that the network remained secure and actions were reported to the Audit and Governance Committee in July 2017 confirming that high levels of preparedness has ensured no patients were impacted as a result. The risk of Cyber attacks remains as a live risk on the CCG’s risk register.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. We have submitted a satisfactory level of compliance with this year’s information governance toolkit assessment of 89% achieving Level 3 on the majority of requirements.

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

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

Business Critical Models

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

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

Third party assurances

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

Control issues

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

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

The organisations economy, efficiency and effectiveness of the use of resources is the responsibility of the Governing Body. The Governing Body undertakes fulfilling this responsibility via its committees whose job it is to deliver and be open to inspection. The Audit and Governance Committee is accountable to the group's Governing Body and its remit is to provide the Governing Body with an independent and objective view of the group's systems, information and compliance with laws, regulations and directions governing the group. It delivers this remit in the context of the group's priorities and the risks associated with achieving them. The Audit and Governance Committee is supported in this work by both Internal and External Auditors, who report regularly to the committee on the agreed work programme, which is developed using a risk based approach to ensure that there is a focus on the most appropriate areas of the group's business. The CCG has changed the provider of both internal and external audit services to ensure that a continuous impartial and objective assessment is made of these systems.

NHS England and the CCG are engaged in a process of continuous assessment against the national CCG Improvement and Assessment Framework. This includes monthly discussions on performance issues, an on-going work plan to provide assurance around Financial Management and scrutinised self-assessment of the CCG's governance and leadership arrangements. As part of this process Executive Directors also attend risk based checkpoint reviews with NHSE where the NHSE Area Team scrutinise the effectiveness of on-going performance. In 2016/17 NHS England rated CCGs against the CCG Improvement and Assessment Framework. The annual assessment identifies areas of strength as well as areas of challenge and improvement. The Clinical Commissioning Group was assessed overall as 'Outstanding'. This made the Group one of only four CCGs in the Country to retain an 'Outstanding' rating for two years. This continues to reflect high performance against the Quality of Leadership indicator as well as the CCG's on-going strong financial management arrangements based on robust planning processes.

Delegation of functions

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

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

Counter fraud arrangements

The CCG has engaged Price Waterhouse Cooper (PwC) to provide Counter Fraud Services. Under this arrangement, an accredited Counter Fraud Specialist undertakes counter fraud work on behalf of the CCG proportionate to identified risks. The Counter Fraud Specialist reports regularly to the Audit and Governance Committee, detailing progress against each of the Standards for Commissioners. The Chief Finance Officer is responsible for championing

Counter Fraud activity across the organisation and proactively and demonstrably acts to ensure the group meets its obligations in tackling fraud, bribery and corruption.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The Head of Internal Audit concluded that Governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control, which potentially put the achievement of objectives at risk. Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance, risk management and control. In making this assessment, the Head of Internal Audit highlighted that medium risk rated weaknesses were identified in individual assignments but these were not significant in aggregate to the system of internal control and none of the individual assignment reports had an overall classification of critical risk. The key factors from individual assignments that contributed to the opinion were as follows:-

Arrangements with the Commissioning Support Unit in relation to procurement

- Additional information gathering and analysis of the market by the CSU would help to inform and support the CCG's procurement decisions
- The CCG should put in place measures to assess the CSU's performance on a periodic basis to ensure value for money for the procurement services provided.

QIPP

- Areas were identified to explore and actions to take which may enable the CCG to identify further QIPP savings
- Potential improvements to the use of programme board meetings to challenge QIPP were identified
- Potential improvements which could be made to the documentation presented to programme board meetings, which would help the CCG focus on priority areas were identified
- Good practice would be for the CCG to report QIPP progress to the Finance and Performance Committee using a dashboard, so that members of the Committee have sufficient information to ask questions, and challenge CCG officers where necessary.

- **Risk Management**

  - Observation of the discussion of risks at the CCG's Governing Body and at its committees noted that there is considerable awareness of the CCG's risks, but that scrutiny of the BAF and of risk registers at meetings could still be improved, including more of those present engaging in the discussion.

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

Area of Audit	Level of Assurance Given
Corporate Governance – Primary Care Co-Commissioning	Not Yet Completed
Better Care Fund	Not Yet Completed
Conflicts of Interest	Low Risk
Risk Management	Low Risk
Finance	Low Risk
Arrangements with CSU	Medium Risk
Audit Follow Up	N/a
QIPP	Medium Risk
Information Governance	Low Risk

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

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

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

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

Conclusion

As Accountable Officer, I confirm that no significant internal control issues have been identified for the CCG in 2017/18. This Governance Statement is a true reflection of the CCG's position at the date of publication.

Remuneration report (information relating to directors)

Remuneration committee report

The Chair of the Remuneration Committee is Mr Peter Price. The other members of the Remuneration Committee in 2017/18 were as follows:

- Dr David Bush
- Dr Julian Morgans.

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

	9.5.17	18.7.17	24.10.17
Members			
Peter Price, Independent Committee Member (Chair)	✓	✓	✓
Dr David Bush, Governing Body Member, CCG	✓	✓	✓
Dr Julian Morgans Governing Body Member, CCG	✓	✓	✓

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

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

Policy on remuneration of senior managers

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

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

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

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

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

A mechanism for reviewing Officer and VSM pay was agreed by the Remuneration Committee in June 2014. The policies adopted provide a framework for considering any uplift to remuneration for VSM and officer members of the Governing Body. They provide an opportunity for consideration of an annual uplift and, in addition, the VSM framework details a structure for the setting and awarding of a performance-related payment. The Committee

has slightly amended this framework during the year to ensure it aligns with the CCG's Performance Development Review Policy and process for setting objectives.

Senior managers' performance-related pay

The Remuneration Committee agreed in 2017/18 that a reserve for an overall maximum of 10 per cent of VSM base pay would be set aside for performance-related payment. Within the 10 per cent, 2.5 per cent is allocated to each of the four domains of the 2016/17 CCG Improvement and Assessment Framework:

- better health
- better care
- leadership
- sustainability.

All performance-related payments are non-consolidated.

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

VSM appraisal relating to 2017/18 performance is scheduled to take place early in the new financial year with a plan for the Remuneration Committee to make a final decision regarding award by the summer.

Policy on duration of contracts, notice periods and termination payments

The policy for senior manager contracts varies according to the role:

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

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

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

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

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

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

Remuneration of Very Senior Managers (VSMs)

In 2017/18 there were no individuals employed or engaged by the CCG earning more than the Prime Minister's salary of £150,000 per annum.

Pension benefits (audited)

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

Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£00
H Hibbs - Accountable Officer	0-2.5	2.5-5	15-20	50-55	344	23	371	0
C Skidmore - Chief Finance & Operating Officer (left post 31/05/17)	0-2.5	0	25-30	70-75	342	4	370	0
T Gallagher - Chief Finance Officer (commenced in post 01/06/17) *	0-2.5	2.5-5.0	30-35	100-105	692	52	761	0
M Hartland - Strategic Finance Officer (commenced in post 01/06/17) **	0-2.5	0	40-45	105-110	609	52	677	0
S Roberts - Chief Nurse & Director of Quality (commenced in post 05/02/18)	0-2.5	0-2.5	30-35	100-105	558	10	632	0
M Garcha - Executive Lead for Nursing & Quality (left post 22/10/17)	0-2.5	0-2.5	30-35	100-105	n/a - over normal retirement age			0
S Marshall - Director of Strategy & Transformation #	2.5-5	0	10-15	0	151	42	195	0
M Hastings - Director of Operations	2.5-5	2.5-5	10-15	30-35	165	34	200	0

These figures have been provided by the Greenbury team at the NHS Business Services Authority (NHSBSA).
Figures are not given for GP Board Members since any pension contributions are processed by NHS England through the GP SOLO process.
As lay members do not receive pensionable remuneration there are no entries in respect of pensions for these members.
* This member works across both Walsall and Wolverhampton CCG. Figures have been provided by Walsall CCG and represent full pension calculations relating to this member's full salary across the both organisations.
** This member works across Dudley, Walsall and Wolverhampton CCGs. Figures have been provided by Dudley CCG and represent full pension calculations relating to this member's full salary across all organisations.
# no lump sum is shown since only a member in the 2008 Section NHS pension scheme.

Cash Equivalent Transfer Values **(audited)**

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

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

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

Real increase in CETV

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

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

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

The figures have been prepared in accordance with the Hutton Review of Fair Pay implementation guidance. The median remuneration is the total remuneration of the staff members lying in the middle of the linear distribution of the total staff, excluding the highest paid director. This is based on the annualised, full-time equivalent remuneration as at the reporting period date i.e. 31 March 2018. A median will not be significantly affected by large or small salaries that may skew an average (mean) hence it is more transparent in highlighting whether a director is being paid significantly more than the middle staff in the organisation.

The banded remuneration of the highest paid member of the Governing Body in the Clinical Commissioning Group in the financial year 2017-18 was £130k-£135k, (2016-17, £155k-£160k). This was 3.7 times (2016-17 4.3 times) the median remuneration of the workforce, which was £36,095, (2016-17 £37,403). This reduction relates to the requirement in 2016/17 to appoint an interim Accountable Officer.

In 2017-18, nil employees (2016-17, nil) received remuneration in excess of the highest paid member of the Governing Body. Remuneration ranged from £6k-£131k, (2016-17 £6k-£159k).

In 2017/18 all staff on Agenda for Change pay bands received a 1% consolidated pay increase. A 1% consolidated pay increase was also applied to all non-Agenda for Change posts (for

example VSM and Governing Body posts). Staff were also eligible to earn an incremental uplift in line with Agenda for Change terms and conditions.

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

Salaries and allowances **(audited)**

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

2017/18						
Name & Title	**Salary (bands of £5000)**	**Expense Payments (taxable) (rounded to the nearest £100)**	**Performance Pay & Bonuses (bands of £5000)**	**Long-term Performance Pay & Bonuses (bands of £5000)**	**All Pension Related Benefits (bands of £2500)**	**Total (bands of £5000)**
	£000	**£00**	**£000**	**£000**	**£000**	**£000**
H Hibbs - Accountable Officer	95-100	0	10-15 #	0	7.5-10	115-120
C Skidmore - Chief Finance & Operating Officer (left post 31/05/17)	15-20	0	0	0	0	15-20
T Gallagher - Chief Finance Officer (commenced in post 01/06/17) *	45-50	0	0	0	12.5-15	60-65
M Hartland - Strategic Finance Officer (commenced in post 01/06/17) **	10-15	0	0	0	22.5-25	35-40
S Roberts - Chief Nurse & Director of Quality (commenced in post 05/02/18)	15-20	0	0	0	2.5-5	15-20
M Garcha - Executive Lead for Nursing & Quality (left post 22/10/17)	50-55	0	0	0	22.5-25	75-80
S Marshall - Director of Strategy & Transformation	100-105	0	10-15 #	0	35-37.5	150-155
Mr M Hastings - Director of Operations	75-80	0	0	0	42.5-45	120-125
Dr S Muneer Reehana - Clinical Chair wef 11/10/17 - GP board member prior to that date	40-45	0	0	0	0	40-45
Dr J Morgans - GP Board Member (left post 13/11/17 to take up the post of Clinical Lead)	10-15	0	0	0	0	10-15
Dr D Bush - GP Board Member	15-20	0	0	0	0	15-20
Dr M Kainth - GP Board Member	15-20	0	0	0	0	15-20
Dr R Rajcholan - GP Board Member	25-30	0	0	0	0	25-30
Dr J Parkes - GP Board Member (commenced in post 11/10/17)	5-10	0	0	0	0	5-10
Dr R Gulati - GP Board Member (commenced in post 11/10/17)	5-10	0	0	0	0	5-10
Dr M Asghar - GP Board Member (commenced in post 11/10/17)	5-10	0	0	0	0	5-10
J Oatridge - Acting Chair until 10/10/17, lay member after that date	45-50	0	0	0	0	45-50
P Roberts - Lay Member (left post 28/09/17)	0-5	0	0	0	0	0-5
P Price - Lay Member	10-15	0	0	0	0	10-15
L Trigg - Lay Member (commenced in post 11/04/17)	5-10	0	0	0	0	5-10
S McKie - Lay Member (commenced in post 01/11/17)	0-5	0	0	0	0	0-5
H Ryan - Board practice manager representative	5-10	0	0	0	0	5-10
A Chandock - Secondary care consultant (commenced in post 27/06/17)	5-10	0	0	0	0	5-10

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

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

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

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

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

2016/17						
Name & Title	Salary (bands of £5000)	Expense Payments (taxable) (rounded to the nearest £100)	Performance Pay & Bonuses (bands of £5000)	Long-term Performance Pay & Bonuses (bands of £5000)	All Pension Related Benefits (bands of £2500)	Total (bands of £5000)
	£000	£00	£000	£000	£000	£000
H Hibbs - Accountable Officer	75-80	0	5-10 **	0	12.5-15	95-100
T Curran - Interim Accountable Officer #	85-90	0	0	0	0	85-90
C Skidmore - Chief Finance and Operating Officer	105-110	0	10-15 **	0	30-32.5	150-155
M Garcha - Executive Lead for Nursing & Quality	90-95	0	0	0	30-32.5	120-125
S Marshall - Director of Strategy & Transformation	90-95	0	10-15 **	0	20-22.5	120-125
Dr D De-Rosa - Chair	65-70	0	0	0	0	65-70
Dr S Muneer Reehana - GP Board Member	20-25	0	0	0	0	20-25
Dr J Morgans - GP Board Member	15-20	0	0	0	0	15-20
Dr D Bush - GP Board Member	15-20	0	0	0	0	15-20
Dr M Kainth - GP Board Member	15-20	0	0	0	0	15-20
Dr R Rajcholan - GP Board Member	25-30	0	0	0	0	25-30
J Oatridge - Lay Member	10-15	0	0	0	0	10-15
P Roberts - Lay Member	5-10	0	0	0	0	5-10
P Price - Lay Member	5-10	0	0	0	0	5-10
H Ryan - Board practice manager representative	5-10	0	0	0	0	5-10
T Fox - Secondary care specialist doctor *	0-5	0	0	0	0	0-5

* Left post 31/08/16

Interim appointment Sept 2016 - Jan 2017

All other members have been in post for the duration of 2016/17

** Estimate - in accordance with the CCG's policy for review of VSM pay the Remuneration Committee will consider and award the bonus relating to 2016-17 early in 2017-18.

Dr Helen Hibbs

Accountable Officer

22 May 2018

Staff report

Staff consultation

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

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

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

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

In the past year, the JNCC has completed work to review staff policies and the CCG's terms and conditions of employment. The CCG have also integrated to a full employee self-service (ESR) which enables CCG staff to record and collate timely and accurate information. The CCG plans to add a fully electronic expenses system in 2018/19.

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

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

A successful Away Day was held in June 2017 which included an external motivational presentation from author Tony Hawks which was well received; the day also included presentations from each department which demonstrated their areas of work and importance within the wider CCG. The event was well received and another Away Day is planned for the same time in 2018.

The CCG also developed Organisational Values based on the outcomes of the 2016 away day. These were developed in conjunction with staff representation and the CCG's Organisational

Development Lead. The group concentrated on establishing a number of key values for the CCG. Further work is planned to incorporate these values into staff appraisals for 2018/19

The CCG's 12 month rolling staff turnover rate is 4.34% up to March 2017 and 12 month rolling sickness is 1.26% up to March 2017 thanks to a proactive approach to managing and motivating staff.

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

Equality

WCCG published its Annual Equality report on 30 March 2018, along with its new Equality Objectives, demonstrating the CCG's commitment to Equality, Inclusion and Human Rights and meeting its legal duties.

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

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

Public sector equality duty

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

Monitoring of equality

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

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

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

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

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

We have identified key equality objectives and aligned these to the Equality Delivery System 2 (EDS2). During 2018 these will both be reviewed and further updates published.

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

https://wolverhamptonccg.nhs.uk/about-us/equality-inclusion-and-human-rights-2016

Staff costs (audited)

2017-18	Total			Admin			Programme		
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits									
Salaries and wages	4,220	3,656	565	2,467	2,359	108	1,753	1,297	456
Social security costs	387	387	0	260	260	0	127	127	0
Employer contributions to the NHS Pension Scheme	441	441	0	304	304	0	137	137	0
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy	4	4	0	4	4	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**5,053**	**4,488**	**565**	**3,036**	**2,927**	**108**	**2,017**	**1,561**	**456**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**5,053**	**4,488**	**565**	**3,036**	**2,927**	**108**	**2,017**	**1,561**	**456**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**5,053**	**4,488**	**565**	**3,036**	**2,927**	**108**	**2,017**	**1,561**	**456**

2016-17	Total			Admin			Programme		
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits									
Salaries and wages	3,801	3,284	517	2,423	2,120	303	1,379	1,165	214
Social security costs	362	362	0	240	240	0	121	121	0
Employer contributions to the NHS Pension Scheme	413	413	0	284	284	0	129	129	0
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy					0	0		0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	4,575	4,058	517	2,947	2,644	303	1,629	1,415	214
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	4,575	4,058	517	2,947	2,644	303	1,629	1,415	214
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	4,575	4,058	517	2,947	2,644	303	1,629	1,415	214

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

Trade Union Facility Time

WCCG supports staff to carry out their trade union duties as per *The Trade Union (Facility Time Publication Requirements) Regulations 2017*.
For the period 17/18 WCCG paid 18 trade union activities hours.

Staff analysis by gender **(audited)**

Staff Grouping	Female	Male	Total
Governing Body	8	9	17
Other Senior Management (Band 8C+)	7	5	12
All Other employees	70	16	86
Grand Total	**85**	**30**	**115**

**Note: Headcount as at 23 March 2018*

Pension liabilities

Details of how pension liabilities are treated in the accounts of the CCG can be found under note 4.5 (page 89) of the annual accounts.

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

Sickness absence data

Figures Converted by DH to Best Estimates of Required Data Items	Statistics Published by NHS Digital from electronic staff record data warehouse			
Average full-time equivalent (FTE) 2016 calendar year	Adjusted FTE days lost to Cabinet Office definitions 2016 calendar year	FTE-Days Available	FTE-Days recorded Sickness Absence	Average Sick Days per FTE
86	583	31,252	946	6.8

As per note 4.3 of the CCG's annual accounts, the average number of staff sick days lost per full-time equivalent (FTE) in 2017 was 6.8 (6.0 in 2016).

Consultancy expenditure

The CCG spent £99k in 2017/18 on consultancy which is included within the gross operating costs note to the accounts (Note 5). The breakdown of this was:

- Johnston Associates Ltd (£36k), primary care estates development management;
- Social Finance Ltd (£57k), Thrive into Work IPS trial;
- Rubicon (£6k), CAMHS review.

Health and safety

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

Our Quality and Safety Committee and Senior Management Team receive regular assurance to confirm how health, safety and wellbeing is being pro-actively managed in the CCG. Some of our achievements this year include:-

- Workplace inspections have been undertaken at quarterly intervals to ensure safety standards are being maintained and where issues have been identified they have been acted upon
- Implementation of the CCG's Health and Safety Risk Assessment.
- Working environments afford sufficient space for our teams to work comfortably and has also been actively managed as teams develop and grow
- Health and Wellbeing of staff remains engrained as part of the organisations Health and Wellbeing agenda, which promotes healthy eating and lifestyles. This has full engagement through the CCG's Staff Forum
- Personal Emergency Evacuation Plans (PEEP) have been undertaken with staff this year.

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

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

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

Health and wellbeing update

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

- Flu vaccinations took place throughout October and November; the uptake was positive at both the session held at CCG and at the local pharmacy scheme offered. This ensured over 60% off staff were vaccinated.
- Staff and organisational values work has been completed. This work has led to a new Personal Development Review being developed which includes the new values.
- Staff Survey findings have been analysed and discussed with staff to assist in impacting change.
- Staff have begun the 'walk and talk' to encourage staff to take the opportunity to hold walking meetings where possible.

- Charitable events and fundraising continue to take place within teams
- Fresh fruit continues to be provided each month
- We have appointed a new CCG Health & Wellbeing Champion.

Fraud

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

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

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

Off-payroll engagements

Off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months are as follows:

	Number
Total number of existing engagements as of 31 March 2018	1
Of which, the number that have existed:	
• For less than one year at the time of reporting	
• For between one and two years at the time of reporting	
• For between two and three years at the time of reporting	1
• For between three and four years at the time of reporting	
• For four or more years at the time of reporting	

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

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and March 2018, for more than £245 per day and that last for longer than six months:

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	1
Of which:	
No. assessed as caught by IR35	
No. assessed as not caught by IR35	1
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	
No. of engagements reassessed for consistency / assurance purposes during the year.	1
No. of engagements that saw a change to IR35 status following the consistency review	

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018:

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure must include both on payroll and off-payroll engagements.	22

Exit packages and severance pay

The CCG has made no payments in respect of exit packages in 2017/18, (nil in 2016/17).

Customer care

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

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

The views and opinions of the patients we commission services for are vital in helping us deliver the best healthcare to our communities. We are committed to providing accessible, equitable and effective services and welcome views about services we provide and are responsible for

commissioning. We actively encourage feedback through public participation groups, and routinely monitor patient experience feedback with service providers in joint engagement meetings and through systems such as Quality Matters.

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

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

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

Emergency preparedness

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

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

In Wolverhampton we work to continually plan for all eventualities on a West Midlands wide footprint. In the last year this included working with providers and NHS England to ensure reassurance in the future for the public following the increased terror threats and Cyber Attack during 2017/18.

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

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

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

A senior managers/executives rota system is in place across the Black Country to deal with issues that arise out of hours. To support senior managers/executives on call, technology is

being developed to streamline the recording of information that will provide a robust evidence trail and ensure a structured approach to the transition between in-hours and out-of-hours.

Payments and charges

Better Payments Practice (prompt payment) Code

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

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

Cost Allocation & Setting of Charges for Information

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

External Auditor's Remuneration

The CCG's external auditor is Grant Thornton UK LLP. Work performed for the CCG in 2017/18 related solely to the statutory audit and amounted to £41,800, (£50,160 inc VAT).

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

Parliamentary Accountability and Audit Report

WCCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at Notes 12, 17 and 2 respectively. An audit certificate and report is also included in this Annual Report at p103.

Dr Helen Hibbs

Accountable Officer

22 May 2018

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	2	0	0
Other operating income	2	(1,895)	(1,878)
Total operating income		**(1,895)**	**(1,878)**
Staff costs	4	5,053	4,575
Purchase of goods and services	5	390,700	338,491
Depreciation and impairment charges		0	0
Provision expense	5	(27)	81
Other Operating Expenditure	5	399	314
Total operating expenditure		**396,125**	**343,462**
Net Operating Expenditure		**394,230**	**341,584**
Finance income			
Finance expense		0	0
Net expenditure for the year		**394,230**	**341,584**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**394,230**	**341,584**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		0	0
Net (gain)/loss on revaluation of Intangibles		0	0
Net (gain)/loss on revaluation of Financial Assets		0	0
Actuarial (gain)/loss in pension schemes		0	0
Impairments and reversals taken to Revaluation Reserve		0	0
Items that may be reclassified to Net Operating Costs			
Net gain/loss on revaluation of available for sale financial assets		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		0	0
Comprehensive Expenditure for the year ended 31 March 2018		**394,230**	**341,584**

Statement of Financial Position as at 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Non-current assets:			
Property, plant and equipment		0	0
Intangible assets		0	0
Investment property		0	0
Trade and other receivables		0	0
Other financial assets		0	0
Total non-current assets		0	0
Current assets:			
Inventories		0	0
Trade and other receivables	8	3,582	3,262
Other financial assets		0	0
Other current assets		0	0
Cash and cash equivalents	9	85	32
Total current assets		**3,667**	3,294
Non-current assets held for sale		0	0
Total current assets		**3,667**	3,294
Total assets		**3,667**	3,294
Current liabilities			
Trade and other payables	10	(35,758)	(23,681)
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions	11	(227)	(296)
Total current liabilities		**(35,985)**	(23,977)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(32,318)**	(20,682)
Non-current liabilities			
Trade and other payables		0	0
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions		0	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(32,318)**	(20,682)
Financed by Taxpayers' Equity			
General fund		(32,318)	(20,682)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(32,318)**	(20,682)

The notes on pages 86 to 102 form part of this statement

The financial statements on pages 76 to 102 were approved by the Governing Body on 22nd May and signed on its behalf by:

Dr Helen Hibbs
Chief Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2018

	General fund	Revaluation reserve	Other reserves	Total reserves
	£'000	£'000	£'000	£'000
Changes in taxpayers' equity for 2017-18				
Balance at 01 April 2017	(20,682)	0	0	**(20,682)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(20,682)**	**0**	**0**	**(20,682)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating expenditure for the financial year	(394,230)			(394,230)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain/(loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain/(loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to/(from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(394,230)**	**0**	**0**	**(394,230)**
Net funding	382,594	0	0	382,594
Balance at 31 March 2018	**(32,318)**	**0**	**0**	**(32,318)**

	General fund	Revaluation reserve	Other reserves	Total reserves
	£'000	£'000	£'000	£'000
Changes in taxpayers' equity for 2016-17				
Balance at 01 April 2016	(25,969)	0	0	(25,969)
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	0
Adjusted NHS Clinical Commissioning Group balance at 31 March 2017	(25,969)	0	0	(25,969)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating costs for the financial year	(341,584)			(341,584)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	0	0	0	0
Net gain/(loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain/(loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to/(from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	(341,584)	0	0	(341,584)
Net funding	346,871	0	0	346,871
Balance at 31 March 2017	(20,682)	0	0	(20,682)

The General Fund reflects the CCG's cumulative net operating costs transferred each year together with the cumulative parliamentary funding. This balance cannot be released back to the SOCNE.

Statement of Cash Flows for the year ended 31 March 2018

	2017-18 £'000	2016-17 £'000
Cash Flows from Operating Activities		
Net operating expenditure for the financial year	(394,230)	(341,584)
Depreciation and amortisation	0	0
Impairments and reversals	0	0
Movement due to transfer by Modified Absorption	0	0
Other gains/(losses) on foreign exchange	0	0
Donated assets received credited to revenue but non-cash	0	0
Government granted assets received credited to revenue but non-cash	0	0
Interest paid	0	0
Release of PFI deferred credit	0	0
Other Gains & Losses	0	0
Finance Costs	0	0
Unwinding of Discounts	0	0
(Increase)/decrease in inventories	0	0
(Increase)/decrease in trade & other receivables	(320)	(827)
(Increase)/decrease in other current assets	0	0
Increase/(decrease) in trade & other payables	12,077	(4,492)
Increase/(decrease) in other current liabilities	0	0
Provisions utilised	(41)	(58)
Increase/(decrease) in provisions	(27)	81
Net Cash Inflow/(Outflow) from Operating Activities	**(382,541)**	(346,881)
Cash Flows from Investing Activities		
Interest received	0	0
(Payments) for property, plant and equipment	0	0
(Payments) for intangible assets	0	0
(Payments) for investments with the Department of Health	0	0
(Payments) for other financial assets	0	0
(Payments) for financial assets (LIFT)	0	0
Proceeds from disposal of assets held for sale: property, plant and equipment	0	0
Proceeds from disposal of assets held for sale: intangible assets	0	0
Proceeds from disposal of investments with the Department of Health	0	0
Proceeds from disposal of other financial assets	0	0
Proceeds from disposal of financial assets (LIFT)	0	0
Loans made in respect of LIFT	0	0
Loans repaid in respect of LIFT	0	0
Rental revenue	0	0
Net Cash Inflow/(Outflow) from Investing Activities	**0**	0
Net Cash Inflow/(Outflow) before Financing	**(382,541)**	(346,881)
Cash Flows from Financing Activities		
Grant in Aid Funding Received	382,594	346,871
Other loans received	0	0
Other loans repaid	0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT	0	0
Capital grants and other capital receipts	0	0
Capital receipts surrendered	0	0
Net Cash Inflow/(Outflow) from Financing Activities	**382,594**	346,871
Net Increase/(Decrease) in Cash & Cash Equivalents	**53**	(10)
Cash & Cash Equivalents at the Beginning of the Financial Year	**32**	42
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies	0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	**85**	32

Notes to the Financial Statements

1. **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2017-18 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on the going concern basis.

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

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

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

- the CCG achieved a cumulative surplus of £11.3m, (in-year surplus of £2.156m), which was in line with the target set by NHS England (see note 19 of the accounts);
- the CCG has an agreed plan with NHS England for 2018/19 with a target cumulative surplus of £10m;
- the CCG's working balances remain constant and cash is managed effectively.

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

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 **Acquisitions & Discontinued Operations**

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

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

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

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

1.5 **Pooled Budgets**

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

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

Notes to the Financial Statements (continued)

1.6 **Critical Accounting Judgements & Key Sources of Estimation Uncertainty**

In the application of the clinical commissioning group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.6.1 ***Critical Judgements in Applying Accounting Policies***

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- Better Care Fund

The clinical commissioning group's management has made a critical judgement in relation to applying accounting policies to the Better Care Fund (BCF). This relates to the arrangements described in the section 75 agreement it has with the City of Wolverhampton Council. The substance of each programme that forms part of the BCF Pooled Budget has been assessed as to whether it meets the principles within IFRS 11: 'Joint Arrangements'. Specific programmes have been assessed as either: (1) Joint Commissioning arrangements under which each Pool Partner accounts for their share of expenditure and balances with the end provider; (2) Lead Commissioning arrangements under which the lead commissioner accounts for expenditure with the end provider and other partners report transactions and balances with the lead commissioner; or (3) Sole Control arrangements under which the provisions of IFRS 11 do not apply. The Fund has been considered a Joint Operation with Lead Commissioning arrangements.

- Leases

The clinical commissioning group applies the tests contained in IAS17 to all of its present and proposed leases in order to ascertain if they should be classed as operating or finance leases. Often the information available can be inconclusive and therefore judgement is made regarding the transfer of the risks and rewards of ownership of the associated assets in order that a decision can be made.

1.6.2 **Key Sources of Estimation Uncertainty**

The following are the key estimations that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- Provisions

When estimating provisions the clinical commissioning group uses estimates based on expert advice from solicitors, other external agents and the experience of its managers.

- Prescribing Costs

The Clinical Commissioning Group recognises the cost of drug prescribing based on data received from the NHS Prescription Pricing Authority (PPA). Reports are received on a monthly basis, but reflect transactions up to the end of February only. March costs are estimated using historical levels of expenditure.

1.7 **Revenue**

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.
Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.8 **Employee Benefits**

1.8.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

1.9 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenses and liabilities in respect of grants are recognised when the clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

Notes to the Financial Statements (continued)

1.10 **Leases**
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.10.1 *The Clinical Commissioning Group as Lessee*
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.11 **Cash & Cash Equivalents**
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.12 **Provisions**
Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

- Timing of cash flows (0 to 5 years inclusive): Minus 2.420% (previously: minus 2.70%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.85% (previously: minus 1.95%)
- Timing of cash flows (over 10 years): Minus 1.56% (previously: minus 0.80%)

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.13 **Clinical Negligence Costs**
The NHS Resolution operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to the NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group.

1.14 **Non-clinical Risk Pooling**
The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.15 **Continuing Healthcare Risk Pooling**
In 2014-15 a risk pool scheme was introduced by NHS England for continuing healthcare claims for claim periods prior to 31 March 2013. Under the scheme the clinical commissioning group contributed annually to a pooled fund, which was used to settle the claims until 2016/17. From April 2017 NHS England have identified a central reserve to cover the payments, including those relating to appeals and the clinical commissioning group is no longer required to make a contribution.

1.16 **Carbon Reduction Commitment Scheme**
Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the clinical commissioning group makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.17 **Contingencies**
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Notes to the Financial Statements (continued)

1.18 **Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.18.1 *Financial Assets at Fair Value Through Profit and Loss*

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the clinical commissioning group's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

In 2017/18 the clinical commissioning group did not hold any financial assets at fair value through profit and loss.

1.18.2 *Held to Maturity Assets*

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

In 2017/18 the clinical commissioning group did not have any held to maturity assets.

1.18.3 *Available For Sale Financial Assets*

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

In 2017/18 the clinical commissioning group did not hold any available for sale financial assets.

1.18.4 *Loans & Receivables*

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Prepayments in respect of the maternity pathway are accrued at the Statement of Financial Position date with movements being recorded within gross operating costs in the year they occur.

Notes to the Financial Statements (continued)

1.19 **Financial Liabilities**
Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.19.1 *Financial Guarantee Contract Liabilities*
Financial guarantee contract liabilities are subsequently measured at the higher of:
- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

In 2017/18 the clinical commissioning group did not hold any financial guarantee contracts.

1.19.2 Financial Liabilities at Fair Value Through Profit and Loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

In 2017/18 the clinical commissioning group did not hold any financial liabilities at fair value through profit and loss.

1.19.3 *Other Financial Liabilities*
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Financial liabilities in respect of partially completed contracts for patient services are accrued at the statement of financial position date with movements being recorded within gross operating costs in the year they occur.

1.20 **Value Added Tax**
Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 **Foreign Currencies**
The clinical commissioning group's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.22 **Third Party Assets**
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

1.23 **Losses & Special Payments**
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.24 **Joint Operations**
Joint operations are activities undertaken by the clinical commissioning group in conjunction with one or more other parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.25 **Research & Development**
Research and development expenditure is charged in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Expenditure on a systematic basis over the period expected to benefit from the project. It should be re-valued on the basis of current cost. The amortisation is calculated on the same basis as depreciation.

1.26 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**
The DHSC Group accounting manual does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to FREM adoption and early adoption is not therefore permitted.
- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)
- IFRS 17: Insurance Contracts (application from 1 January 2021)
- IFRIC 22: Foreign Currency Transactions and Advance Consideration (application from 1 January 2018)
- IFRIC 23: Uncertainty over Income Tax Treatments (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2017-18, were they applied in that year.

2. Other Operating Revenue

	2017-18 Total	2017-18 Admin	2017-18 Programme	2016-17 Total
	£'000	£'000	£'000	£'000
Recoveries in respect of employee benefits	0	0	0	0
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	0	0	0	0
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	71	0	71	177
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	0	0	0	0
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Non cash apprenticeship training grants revenue	0	0	0	0
Other revenue	1,824	0	1,824	1,701
Total other operating revenue	**1,895**	**0**	**1,895**	1,878

Programme revenue is revenue received for activities for which the sole or primary purpose is to improve the quality of health services.

Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the clinical commissioning group and credited to the General Fund.

3. Revenue

The clinical commissioning group receives no revenue from the sale of goods and services.

4. Employee Benefits and Staff Numbers

4.1.1 Employee benefits 2017/18

	Total	**Permanent Employees**	**Other**
	£'000	**£'000**	**£'000**
Salaries and wages	4,220	3,656	565
Social security costs	387	387	0
Employer Contributions to NHS Pension scheme	441	441	0
Other pension costs	0	0	0
Apprenticeship Levy	4	4	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**5,053**	**4,488**	**565**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	**5,053**	**4,488**	**565**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**5,053**	**4,488**	**565**

4.1.2 Employee benefits 2016/17

	Total	Permanent Employees	Other
	£'000	£'000	£'000
Salaries and wages	3,801	3,284	517
Social security costs	362	362	0
Employer Contributions to NHS Pension scheme	413	413	0
Other pension costs	0	0	0
Apprenticeship Levy	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	4,575	4,058	517
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	4,575	4,058	517
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	4,575	4,058	517

Further details regarding staff costs are contained within the Remuneration Report of the Annual Report.

4.2. Average number of people employed

	2017-18			2016-17		
	Total Number	**Permanently employed Number**	**Other Number**	Total Number	Permanently employed Number	Other Number
Total	**91**	**85**	**6**	82	77	5

4.3. Staff sickness absence and ill health retirements

	2017-18 Number	2016-17 Number
Total Days Lost	583	462
Total Staff Years	86	77
Average working Days Lost	7	6

	2017-18 Number	2016-17 Number
Number of persons retired early on ill health grounds	0	0
	£'000	£'000
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme

4.4. Exit packages agreed in the financial year

The CCG has made no payments in respect of exit packages (nil in 2016/17).

The CCG has made no special payments in respect of employee departures (nil in 2016/17).

4.5. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

For 2017-18, employers' contributions of £441,456 were payable to the NHS Pensions Scheme (2016-17: £417,021) were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.1.

5. Operating Expenses

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	4,522	2,505	2,017	3,984
Executive governing body members	531	531	0	591
Total gross employee benefits	**5,053**	**3,036**	**2,017**	4,575
Other costs				
Services from other CCGs and NHS England	2,349	1,081	1,268	2,392
Services from foundation trusts	51,966	0	51,966	49,865
Services from other NHS trusts	201,124	0	201,124	193,493
Sustainability Transformation Fund	0	0	0	0
Services from other WGA bodies	0	0	0	44
Purchase of healthcare from non-NHS bodies	38,840	0	38,840	30,795
Purchase of social care	2	0	2	0
Chair and Non Executive Members	261	261	0	247
Supplies and services – clinical	1,354	0	1,354	1,138
Supplies and services – general	9,941	292	9,649	10,808
Consultancy services	99	31	68	101
Establishment	1,401	162	1,239	1,069
Transport	12	12	0	7
Premises	829	207	622	784
Impairments and reversals of receivables	7	0	7	32
Inventories written down and consumed	0	0	0	0
Depreciation	0	0	0	0
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets				
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees *	50	50	0	63
Other non statutory audit expenditure				
· Internal audit services	73	73	0	57
· Other services	0	0	0	2
General dental services and personal dental services	0	0	0	0
Prescribing costs	47,097	0	47,097	46,034
Pharmaceutical services	0	0	0	0
General ophthalmic services	325	0	325	303
GPMS/APMS and PCTMS **	34,986	0	34,986	941
Other professional fees excl. audit	23	23	0	125
Legal fees	58	53	5	27
Grants to Other bodies	0	0	0	0
Clinical negligence	1	1	0	1
Research and development (excluding staff costs)	20	20	0	34
Education and training	170	25	145	113
Change in discount rate	0	0	0	0
Provisions #	(27)	0	(27)	81
Funding to group bodies	0	0	0	0
CHC Risk Pool contributions ~	0	0	0	330
Non cash apprenticeship training grants	0	0	0	0
Other expenditure ^	110	0	110	0
Total other costs	**391,072**	**2,291**	**388,781**	338,887
Total operating expenses	**396,125**	**5,327**	**390,798**	343,462

Programme expenditure is expenditure incurred on direct payments for the provision of healthcare or healthcare services.

Programme expenditure includes £38m in relation to services commissioned under Better Care Fund pooled budget arrangements. The majority of this expenditure is reflected within healthcare purchased from NHS and non-NHS bodies with £9.6m shown against supplies and services general. Note 16 provides further detail regarding this pooled budget.

Admin expenditure is all other expenditure and will include items such as staff costs, hosting arrangements and accommodation costs.

The liability in respect of partially completed patient spells is included within the statement of financial position with annual movements being charged to gross operating costs. The movement in 2017/18 was an increase of £138k which is reflected within services from foundation trust & other NHS trusts in the gross operating costs shown above.

In addition a prepayment is included within the statement of financial position in relation to maternity services, with the corresponding credit movement included within services from other NHS trusts in the gross operating costs shown above. This is to recognise that an upfront block payment is made for maternity pathways which include all episodes of care from first ante-natal appointment to delivery. The movement in 2017/18 was a reduction in the prepayment of £95k.

* Figure is shown gross of VAT which cannot be reclaimed. The net figure is £41,800.

** The increase in expenditure in this area is as a result of the CCG taking on responsibility for the commissioning of Delegated Primary Care (General Medical Services) from NHSE on 1 April 2017.

Movements in provisions charged to operating expenses.

~ The CCG's contribution to the national CHC Risk Pool in 2017/18 was nil, (£330k in 2016/17). This pool was created in 2014/15 by NHS England for continuing healthcare claims for periods prior to 31 March 2013 and was used to settle these claims. The CCG is no longer required to make a contribution to this pool since a central reserve has been created by NHS England to cover these payments.

^ Other expenditure relates to special payments - further details are disclosed within note 17, Losses and Special Payments.

The CCG's contract with its external auditor provides for a limitation of the auditor's liability. The principal terms of this limitation are:

- the total aggregate liability of each Party to the other Party for each year of the Contract shall be subject to a limit of £2 million for all defaults resulting in direct loss or damage to the property of the other party, and;

- in respect of all other defaults, claims, losses or damages whether arising from breach of contract, misrepresentation (whether tortious or statutory), tort (including negligence), breach of statutory duty or otherwise shall in no event exceed the greater of the sum of £2 million or a sum equivalent to 125% of the annual Contract Charges.

6. Payment Practice

6.1. Better Payment Practice Code

Measure of compliance	**2017-18 Number**	**2017-18 £'000**	2016-17 Number	2016-17 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	8,710	120,160	8,179	83,434
Total Non-NHS Trade Invoices paid within target	8,501	118,902	7,766	81,322
Percentage of Non-NHS Trade invoices paid within target	**97.6%**	**99.0%**	95.0%	97.5%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,618	255,987	3,294	253,314
Total NHS Trade Invoices Paid within target	3,598	255,505	3,260	253,110
Percentage of NHS Trade Invoices paid within target	**99.4%**	**99.8%**	99.0%	99.9%

The Better Payment Practice Code requires the clinical commissioning group to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The clinical commissioning group is an approved signatory of the Code.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2017-18 £'000**	2016-17 £'000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	0

7. Operating Leases

7.1 As Lessee

7.1.1 Payments recognised as an Expense	2017-18				2016-17			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payments recognised as an expense								
Minimum lease payments	0	674	6	**680**	0	681	7	689
Contingent rents	0	0	0	**0**	0	0	0	0
Sub-lease payments	0	0	0	**0**	0	0	0	0
Total	**0**	**674**	**6**	**680**	0	681	7	689

The clinical commissioning group held an operating lease with University of Wolverhampton Science Park Limited for the rental of office accommodation at a cost of £98k in 2017/18, (£149k in 2016/17). This reduction relates to a re-assessment of the treatment of service charges in relation to this accommodation.

Minimum lease payments in respect of buildings also include void and subsidy charges of £408k, (£363k in 2016/17) from NHS Property Services Limited and £168k, (£169k in 2016/17) from Community Health Partnerships.

Other leases of £6k relate to leases held with Canon UK for the rental of photocopiers, (£7k in 2016/17).

7.1.2 Future minimum lease payments	2017-18				2016-17			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payable:								
No later than one year	0	40	4	**44**	0	38	0	38
Between one and five years	0	0	0	**0**	0	0	12	12
After five years	0	0	0	**0**	0	0	0	0
Total	**0**	**40**	**4**	**44**	0	38	12	50

Minimum lease payments for buildings relate to the operating lease with University of Wolverhampton Science Park Limited.

Whilst our arrangements with NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed. Consequently this note does not include future minimum lease payments for these arrangements.

7.2 As Lessor

The clinical commissioning group does not have any leasing arrangements as a lessor.

8. Trade and Other Receivables	**Current 2017-18 £'000**	**Non-current 2017-18 £'000**	Current 2016-17 £'000	Non-current 2016-17 £'000
NHS receivables: Revenue	1,486	0	1,329	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	882	0	847	0
NHS accrued income	864	0	797	0
Non-NHS and Other WGA receivables: Revenue	179	0	194	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	126	0	9	0
Non-NHS and Other WGA accrued income	9	0	60	0
Provision for the impairment of receivables	(7)	0	(36)	0
VAT	39	0	61	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables and accruals	4	0	0	0
Total Trade & other receivables	**3,582**	**0**	3,262	0
Total current and non current	**3,582**		3,262	
Included above:				
Prepaid pensions contributions	0		0	

NHS prepayments and accrued income include £752k in relation to the maternity pathway prepayment relating to activity with the Royal Wolverhampton NHS Trust.

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to clinical commissioning groups to commission services, no credit scoring of them is considered necessary.

The majority of other receivables that are neither past due nor impaired relate to other NHS bodies or local government. No credit scoring of these bodies is considered necessary.

8.1 Receivables past their due date but not impaired	**2017-18 £'000 DH Group Bodies**	**2017-18 £'000 Group Bodies**	2016-17 £'000 All receivables prior years
By up to three months	805	53	706
By three to six months	0	0	0
By more than six months	5	0	1
Total	**810**	**53**	707

£855k of the amount above has subsequently been recovered post the statement of financial position date.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2018.

8.2 Provision for impairment of receivables	**2017-18 £'000 DH Group Bodies**	**2017-18 £'000 Group Bodies**	2016-17 £'000 All receivables prior years
Balance at 01 April 2017	0	(36)	(146)
Amounts written off during the year	0	0	60
Amounts recovered during the year	0	36	82
(Increase) decrease in receivables impaired	0	(7)	(32)
Balance at 31 March 2018	**0**	**(7)**	(36)

	2017-18 £'000	2016-17 £'000
Receivables are provided against at the following rates:		
NHS debt	0%	0%
Local authority debt greater than 90 days old	100%	100%
Local authority debt less than 90 days old	0%	0%
All other non-NHS debt greater than 90 days old	100%	100%
All other non-NHS debt less than 90 days old	0%	17%

9. Cash and Cash Equivalents

	2017-18 £'000	2016-17 £'000
Balance at 01 April 2017	32	42
Net change in year	53	(10)
Balance at 31 March 2018	**85**	32
Made up of:		
Cash with the Government Banking Service	85	32
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**85**	32
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	0
Balance at 31 March 2018	**85**	32

10. Trade and Other Payables

	Current 2017-18 £'000	**Non-current 2017-18 £'000**	Current 2016-17 £'000	Non-current 2016-17 £'000
Interest payable	0	0	0	0
NHS payables: revenue	1,473	0	704	0
NHS payables: capital	0	0	0	0
NHS accruals	5,822	0	3,084	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	5,482	0	4,420	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	21,428	0	14,796	0
Non-NHS and Other WGA deferred income	20	0	184	0
Social security costs	59	0	55	0
VAT	0	0	0	0
Tax	52	0	47	0
Payments received on account	0	0	0	0
Other payables and accruals	1,422	0	390	0
Total Trade & Other Payables	**35,758**	**0**	23,681	0
Total current and non-current	**35,758**		23,681	

NHS accruals include £1,500k in respect of partially completed patient spells. £1,419k of this relates to activity with the Royal Wolverhampton NHS Trust.

Other payables include £65k outstanding pension contributions at 31 March 2018, (£64k as at 31 March 2017).

11. Provisions

	Current 2017-18 £'000	**Non-current 2017-18 £'000**	Current 2016-17 £'000	Non-current 2016-17 £'000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	0	0
Continuing care	37	0	47	0
Other	190	0	249	0
Total	**227**	**0**	296	0
Total current and non-current	**227**		296	

	Continuing Care £'000	**Other £'000**	**Total £'000**
Balance at 01 April 2017	**47**	**249**	**296**
Arising during the year	0	52	52
Utilised during the year	(3)	(39)	(42)
Reversed unused	(7)	(72)	(79)
Unwinding of discount	0	0	0
Change in discount rate	0	0	0
Transfer (to)/from other public sector body	0	0	0
Transfer (to)/from other public sector body under absorption	0	0	0
Balance at 31 March 2018	**37**	**190**	**227**
Expected timing of cash flows:			
Within one year	37	190	227
Between one and five years	0	0	0
After five years	0	0	0
Balance at 31 March 2018	**37**	**190**	**227**

The Continuing Care provision includes claims for individuals who have their care package assessed late and are entitled to a reimbursement of their nursing home fees. This late assessment is due to a delay in nursing homes advising the clinical commissioning group of the individual's placement. This is not expected to be resolved in the near future and a provision is therefore required for future cases. Costs have been estimated based on the value of cases settled in 2017/18 and it is expected that the provision will be utilised within one year. The Continuing Care provision also includes an estimate of claims for cross border placements where the corresponding clinical commissioning group is still to complete the assessment of the individual's case. The provision has been based on similar cases settled in 2017/18 and it is expected that this will also be utilised within one year.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the clinical commissioning group. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this clinical commissioning group at 31 March 2018 is £70k.

Included within other provisions is £74k relating to estimated property charges. This is in respect of properties owned by NHS Property Services occupied by 3rd sector healthcare providers from which the CCG commissions services. Under the terms of the contracts with the providers the CCG is liable to fund property charges. This provision is expected to be settled within one year.

Other provisions also include £81k in respect of dilapidations and £34k in respect of legal fees.

The clinical commissioning group currently has no legal claims lodged with the NHS Litigation Authority, (nil in 2016/17).

Nil is included in the provisions of the NHS Litigation Authority as at 31 March 2018 in respect of clinical negligence liabilities of the clinical commissioning group, (nil in 2016/17).

12. Contingencies

The clinical commissioning group has no quantifiable contingent assets or liabilities as at 31st March 2018.

The year-end report from the NHS Litigation Authority confirms that the clinical commissioning group has no member liability as at 31st March 2018.

13. Financial Instruments

13.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group's Prime Financial Policies agreed by the Governing Body. Treasury activity is subject to review by the clinical commissioning group and internal auditors.

13.1.1 Currency risk

The clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The clinical commissioning group has no overseas operations. The clinical commissioning group and therefore has low exposure to currency rate fluctuations.

13.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

13.1.3 Credit risk

Because the majority of the clinical commissioning group's revenue comes from parliamentary funding, the clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

13.1.4 Liquidity risk

The clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The clinical commissioning group draws down cash to cover expenditure, as the need arises. The clinical commissioning group is not, therefore, exposed to significant liquidity risks.

13. Financial Instruments (continued)

13.2 Financial assets

	At 'fair value through profit and loss' 2017-18 £'000	**Loans and Receivables 2017-18 £'000**	**Available for Sale 2017-18 £'000**	**Total 2017-18 £'000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	2,350	0	2,350
· Non-NHS	0	189	0	189
Cash at bank and in hand	0	85	0	85
Other financial assets	0	4	0	4
Total at 31 March 2018	**0**	**2,628**	**0**	**2,628**

	At 'fair value through profit and loss' 2016-17 £'000	Loans and Receivables 2016-17 £'000	Available for Sale 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	2,127	0	2,127
· Non-NHS	0	254	0	254
Cash at bank and in hand	0	32	0	32
Other financial assets	0	0	0	0
Total at 31 March 2017	0	2,413	0	2,413

13.3 Financial liabilities

	At 'fair value through profit and loss' 2017-18 £'000	**Other 2017-18 £'000**	**Total 2017-18 £'000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	7,295	7,295
· Non-NHS	0	28,332	28,332
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2018	**0**	**35,627**	**35,627**

	At 'fair value through profit and loss' 2016-17 £'000	Other 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	3,788	3,788
· Non-NHS	0	19,606	19,606
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2017	0	23,394	23,394

14. Operating Segments

The term 'Chief Operating Decision Maker', per IFRS8, identifies a function, not necessarily a manager with a specific title. That function is to allocate resources to and assess the performance of the operating segments of an entity. The CCG's chief operating decision maker is its group of executive and non-executive officers (the Governing Body). The CCG considers it has only one operating segment: commissioning of healthcare services. Finance and performance information is reported to the Governing Body as one segment and these financial statements have been prepared in accordance with this reporting.

15. Pooled Budgets

Wolverhampton CCG entered into a pooled budget arrangement with Wolverhampton City Council on 1st April 2015. This is a section 75 (NHS Act 2006) partnership agreement relating to the commissioning of health and social care services under the Better Care Fund (BCF). The BCF has been established by the Government and it is a requirement of the Fund that that the CCG and the Council establish a pooled fund for this purpose. The Host Partner is Wolverhampton City Council.

The partners' contributions to the Fund are outlined below. The share of any over/(under) spend is allocated according to the Section 75 agreement.

	2017-18	2016-17
	£'000	£'000
Pool Expenditure:		
Community	57,237	48,884
Dementia	3,019	3,056
Mental Health	10,514	10,525
Total Pool Expenditure	**70,770**	62,465
Gross Funding:		
Wolverhampton CCG	37,549	35,126
Wolverhampton City Council	29,264	21,643
Total Gross Funding	**66,813**	56,769
Net Over/(Under) Spend	**3,957**	5,696
Share of Over/(Under Spend):		
Wolverhampton CCG	2,791	3,893
Wolverhampton City Council	1,166	1,803
	3,957	5,696

16. Related Party Transactions

During the year the following Governing Body members or members of the key management staff have declared interests with other organisations that have undertaken material transactions with the clinical commissioning group:

	2017/18				2016/17			
	Payments to Related Party £'000	**Receipts from Related Party £'000**	**Amounts owed to Related Party £'000**	**Amounts due from Related Party £'000**	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Dr H Hibbs; Chief Officer; Organisational Medical Director and Shareholder Parkfield Wolverhampton Medical Services Ltd.	2,338	0	0	0	145	0	0	0
Mr T Gallagher; Chief Finance Officer (wef 01/06/17); Chief Finance Officer Walsall CCG Mr M Hartland; Strategic Finance Officer (wef 01/06/17); Strategic Finance Officer Walsall CCG Mr J Oatridge; Acting Chair/Lay Member; Member of the Governing Body Walsall CCG	59	37	74	1	9	0	0	5
Mr M Hartland; Strategic Finance Officer (wef 01/06/17); Chief Finance Officer Dudley CCG	50	5	0	0	40	0	0	5
Mr A Chandock; Secondary Care Consultant (wef 27/06/17); Consultant Gynaecologist at Heart of England NHS Foundation Trust	302	0	0	0	635	0	3	0
Ms H Ryan; Practice Manager Representative, Practice Manager Penn Manor Medical Centre	1,365	0	0	0	143	0	0	0
Mrs Claire Skidmore, Chief Finance & Operating Officer, Public Sector Director of Community Health Partnerships	165	0	0	9	251	0	0	0
Dr J Morgans, GP Board Member until 13/11/17, Shareholder, Wolverhampton Doctors on Call Ltd	0	0	0	0	18	0	17	0

The following General Practitioners were members of the clinical commissioning group Governing Body during 2017/18. Payments were made to the practices of these GPs for GMS/PMS/APMS and enhanced services delivered to the population of Wolverhampton. Other payments were also made in respect of items such as the Prescribing Incentive Scheme and collaborative fees. Payments listed are in relation to the whole GP practice and therefore do not reflect the remuneration of the individual. The increase compared to 2016/17 is due to the CCG taking on responsibility for the commissioning of Delegated Primary Care (General Medical Services) from NHSE on 1 April 2017.

GP Governing Body Member	**Practice**	**2017-18 £000**	2016-17 £000
Dr D Bush, GP Member	Penn Surgery	578	41
Dr R Rajcholan, GP Member	Ashmore Park Health Centre	432	31
Dr M Kainth, GP Member	Primrose Lane Clinic	354	36
Dr S Reehana, Clinical Chair Dr M Asghar, GP Member	Grove Medical Centre	1,442	51
Dr J Parkes, GP Member	Alfred Squire Medical Practice	1,225	118
Dr R Gulati, GP Member	Cannock Road Medical Practice	671	31
Dr J Morgans; GP Member until 13/11/17	Dr Morgans and Partners	1,713	149

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a number of material transactions with entities for which the Department is regarded as the parent Department. These are:

	2017-18 £000	2016-17 £000
The Royal Wolverhampton NHS Trust	194,637	194,457
NHS Business Services Authority	46,194	44,782
Black Country Partnership NHS Foundation Trust	30,318	29,231
West Midlands Ambulance Service NHS Trust	11,088	10,012
The Dudley Group of Hospitals NHS Foundation Trust	4,996	4,601
NHS England (including Arden & GEM CSU and Midlands & Lancs CSU)	1,353	1,395

In addition, the clinical commissioning group has had a number of transactions with other government departments and other central and local government bodies. Most of these transactions have been with Wolverhampton City Council, (£55,337k in 2017/18, £46,187k in 2016/17). The majority of these payments relate to the Better Care Fund pooled budget. Payments have been made back to the clinical commissioning group from the council of £37,265k for health related schemes.

17. Losses and Special Payments

17.1 Losses

The total number of the clinical commissioning group's losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2017-18 Number	**Total Value of Cases 2017-18 £'000**	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000
Administrative write-offs	2	0	0	0
Fruitless payments	0	0	0	0
Store losses	0	0	0	0
Book Keeping Losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	0	0	0	0
Claims abandoned	0	0	0	0
Total	**2**	**0**	0	0

17.2 Special payments

	Total Number of Cases 2017-18 Number	**Total Value of Cases 2017-18 £'000**	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000
Compensation payments	0	0	0	0
Extra contractual Payments	1	110	0	0
Ex gratia payments	0	0	0	0
Extra statutory extra regulatory payments	0	0	0	0
Special severance payments	0	0	0	0
Total	**1**	**110**	0	0

This extra contractual payment related to an out of court settlement with a healthcare provider. This was a counter claim to the amount being claimed by the provider and was in full and final settlement.

18. Events After the end of the Reporting Period

The clinical commissioning group does not have any events after the end of the reporting period to disclose.

19. Financial Performance Targets

Clinical Commissioning Groups have a number of financial duties under the NHS Act 2006 (as amended).
Performance against those duties was as follows:

	2017-18 Target	**2017-18 Performance**	2016-17 Target	2016-17 Performance
223H(1) Expenditure not to exceed income *	398,281	396,125	353,891	343,462
223I(2) Capital resource use does not exceed the amount specified in Directions	0	0	0	0
223I(3) Revenue resource use does not exceed the amount specified in Directions	396,386	394,230	352,013	341,584
223J(1) Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
223J(2) Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
223J(3) Revenue administration resource use does not exceed the amount specified in Directions	5,535	5,326	5,555	5,477

* 2017/18 figures show in-year performance to reflect revised NHSE reporting requirements, prior year figures show cumulative performance

Note: For the purposes of 223H(1); expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and, income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).