NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commission Group

Annual Report 2020/21

Contents

Foreword from the Clinical Chair

It's hard to know where to start when we look back over this last extraordinary year.

Everyone in our community has been affected by the COVID-19 pandemic. Some of us have lost loved ones, friends and colleagues to the virus and to those people I extend my deepest sympathy. Many of us are still living with the longer-term effects of the virus, whether it's poorer mental health, Long-COVID, postponed operations or other treatment, financial difficulties or disrupted plans for education, travel, weddings and the other parts of 'normal' life which have been put on hold. To those people I extend my sincere hopes for brighter days ahead.

However, in other ways, the huge challenges of the last year have brought out the very best in people and there is much to celebrate, and for that I want to say an enormous and heartfelt thank you.

Alongside the voluntary sector and our local communities, the NHS, our Local Authorities and all parts of the public sector have pulled together to ensure our response to the pandemic has been effective and coordinated.

To all NHS and care workers on the frontline treating patients over the past year – COVID or non-COVID – thank you. To my fellow GPs and all colleagues in primary care and the fantastic volunteers who have supported the vaccination programme – thank you. To everyone behind the scenes who has supported them and kept the NHS going – thank you.

The demands on our workforce over the last year have been unprecedented and looking after their wellbeing has been key to helping them cope with those demands. To everyone who has provided wellbeing support – from online meditation and mindfulness sessions to free pizzas – thank you.

The pandemic brought about significant and rapid changes to the way everyone across health and care services works and those changes had to be made quickly. To all those patients and the wider public who have adapted to those changes, embraced them and have been so understanding – thank you. To everyone who has followed the guidelines to help control the spread of COVID-19 and ensure health and care services have not been overwhelmed – thank you. To all those thousands of people across Oxfordshire who have taken up the opportunity to be vaccinated – thank you.

The health inequalities which exist even in the most affluent areas of the country, have been brought into sharp focus by the pandemic. Going forward, our efforts to tackle these inequalities must be ramped up as we move forward to ensure that everyone in our communities has access to good quality healthcare and the resources to take more control of their own wellbeing in future.

This is my last contribution to Oxfordshire Clinical Commissioning Group's Annual Report as I am leaving OCCG after eight rewarding years to join NHS England and NHS Improvement as Deputy Medical Director for Primary Care. Which brings me to my final thank you: to all my colleagues at OCCG who have worked so hard for the people of Oxfordshire and supported me in my role as Clinical Chair. I wish you all the best for the future.

Dr Kiren Collison

Clinical Chair

Performance Report

‘By working together, we will have a healthier population, with fewer inequalities, and health services that are high quality, cost effective and sustainable.’

What we do

NHS Oxfordshire Clinical Commissioning Group (OCCG) is the statutory organisation in Oxfordshire that plans, buys and oversees health services for more than 770,000 people from a range of NHS, voluntary, community and private sector providers.

OCCG is responsible for commissioning non-specialist hospital services, both urgent and planned care. As well as commissioning GP services, mental health and learning disability services, ambulance services and community services such as district nursing and physiotherapy. Specialist hospital services, dentistry, pharmacy and optician services are commissioned by NHS England (NHSE). Public Health is provided by Oxfordshire County Council (OCC), and includes drug and alcohol, sexual health, health visiting and health promotion services.

OCCG is a member organisation of 67 GP practices in Oxfordshire; we work with local people, voluntary sector organisations and partners Oxfordshire County Council (OCC), local District Councils, GPs and Primary Care Networks, Oxford University Hospitals NHS Foundation Trust (OUH), Oxford Health NHS Foundation Trust (Oxford Health) and South Central Ambulance NHS Foundation Trust (SCAS).

OCCG is part of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) which covers a population of 1.8 million, three Clinical Commissioning Groups (CCGs) including OCCG, six NHS Trusts, 14 local authorities and 166 GP practices, working together as 45 Primary Care Networks. Integrated care systems aim to bring the NHS together with Local Authorities to further the integration of health and care; improve the health of local populations; transform the quality of care provided and ensure they are sustainable within allocated funding.

In Oxfordshire, the Health and Wellbeing Board (H&WB) is responsible for improving the health and wellbeing of the people of Oxfordshire. The Board is chaired by the leader of Oxfordshire County Council and OCCG’s Clinical Chair is the vice-chair. The H&WB is a partnership between Local Government, the NHS and the people of Oxfordshire; board members include local GPs, senior Councillors, Healthwatch Oxfordshire and senior officers from the NHS and Local Government.

OCCG has a duty to improve the quality of services commissioned; reduce health inequalities; involve the public and patients in commissioning decisions and deliver a Health and Wellbeing Strategy. This Annual Report describes how OCCG carries out its duties.

The Oxfordshire Joint Health and Wellbeing Strategy (2018/2023) was developed during 2018. Coordinated by OCC and OCCG the new strategy was produced with input from the public, voluntary sector and health and social care partners. It aims to improve the health and wellbeing of local people and reduce health inequalities across the county. This strategy guides the work of OCCG over the coming years alongside our local implementation of the NHS Long Term Plan.

During the reporting financial year 2020/21 the COVID-19 pandemic has continued; the scale of pandemic and the challenges faced by the NHS over the past 12 months has been unparalleled. The pandemic has had a significant impact on public sector resources; the NHS has been under considerable pressure, with new and changing working arrangements affecting teams in organisations to varying degrees.

In response to the COVID-19 pandemic, guidance for annual reporting requirements has been issued by the Department of Health and Social Care in the Accounting Manual for 2020/21. In the guidance there is an 'option to omit' some information; this includes the omission of a full performance analysis and sickness absence data. As such the following performance report is an overview of key performance information; an overview from the Accountable Officer giving his perspective on the performance of the organisation and a summary of the key issues and risks of OCCG.

Clinical Leadership within commissioning

Clinical commissioning groups were designed to put GPs at the heart of NHS planning decisions. Clinical involvement and clinical leadership are key to high-quality commissioning. This involves engaging with all GPs in the local area so their experience and expertise can inform the decisions being taken. Clinical leaders are working at all levels of the CCG, including the CCG Clinical Chair, GPs and other clinicians providing a majority sitting with senior managers at the CCG Board and other committees, driving service development and responding to the pandemic.

Clinical leadership helps to ensure the CCG remains patient centred. The clinicians working for the CCG also all work in clinical practice with regular contact with patients, carers and families.

During this past year, the COVID-19 pandemic has dominated the work of the CCG and our clinicians have been providing clinical leadership in decisions relating to healthcare and the vaccination programme.

Despite the practical difficulties in maintaining services during the pandemic, with higher levels of staff absence and risks of infection, they supported the work needed to quickly revise the way GP practices organised their services to ensure patients

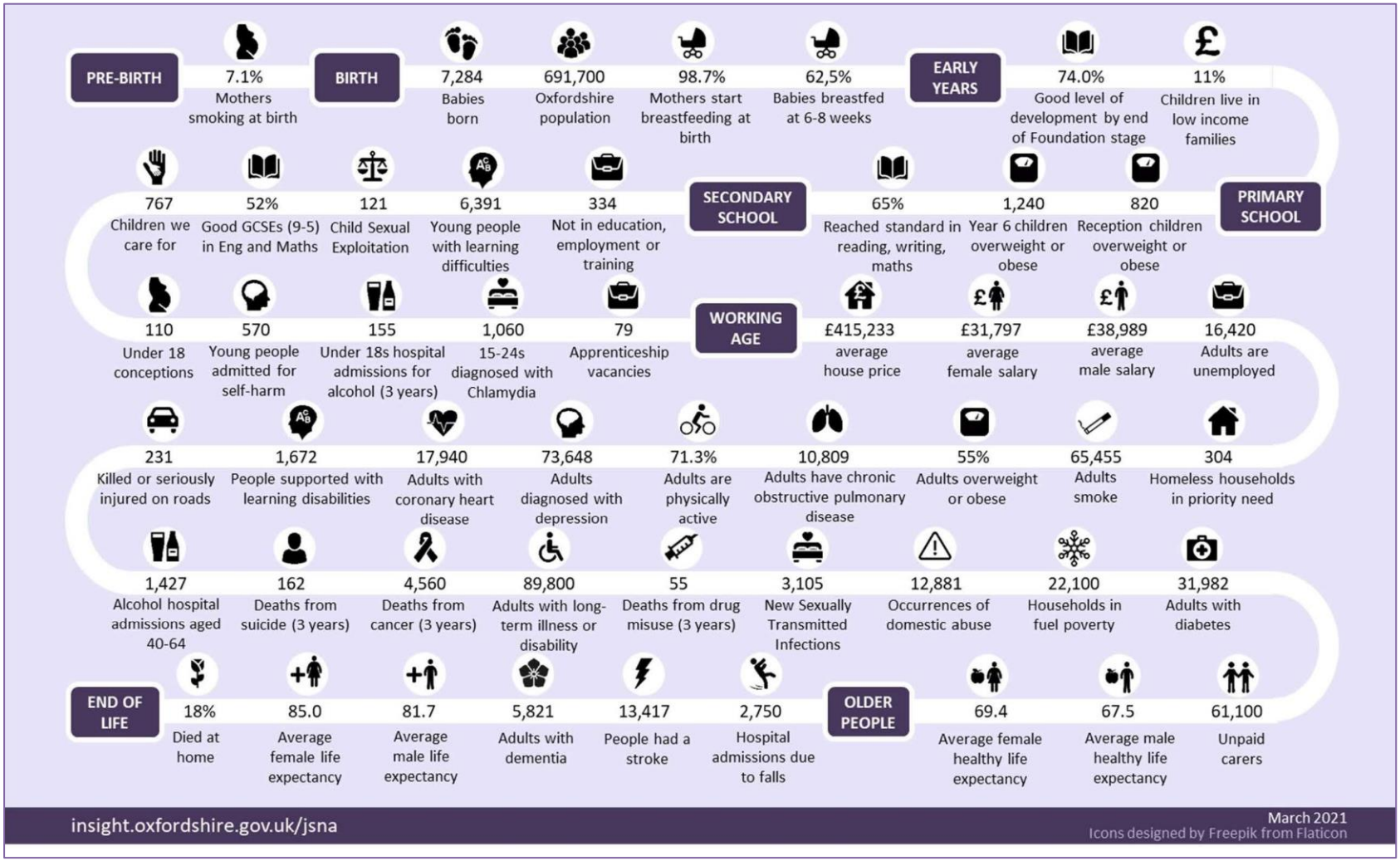
could continue to access the care and support needed. They have also been working with health and care partners to ensure appropriate arrangements were in place for other services so that patients with urgent conditions such as cancer could continue to access care and treatment.

Clinical events have been hosted online where clinical leaders shared the latest evidence for treating patients, the research into new treatments and advice on safe and effective services in primary care. These events have been led by clinicians with positive effects on recovery rates.

Clinical leadership has been present and driving all major projects. Despite the pandemic, some areas of work have needed to continue while others have paused until the pandemic has passed. These projects benefit from clinical input from primary care, often working alongside clinical partners from community, mental health and hospital services.

Developing the clinical leaders of the future is critical to sustaining this way of working. A review of clinical leadership in the CCG, led by the clinical chair, resulted in revising the portfolios held by clinicians on the Board and providing strong clinical leaders for the three Primary Care Networks Groups (North, City and South) and the four priority transformation areas of work. This new model was implemented at the start of the year. Later in this report there is a summary of the achievements of each of the clinical leaders for the CCG.

Oxfordshire's Population



The information above is from the Joint Strategic Needs Assessment for Oxfordshire 2021 which provides information about the county's population and the factors affecting health, wellbeing, and social care needs. It brings together information from different sources to create a shared evidence base. This informs OCCG's strategy and supports its service planning and decision-making. To read more about the health needs of Oxfordshire's population visit Oxfordshire County Council website.

Overview from Dr James Kent, Accountable Officer

No one could have predicted the extraordinary year that has passed; the COVID-19 pandemic has been all consuming and has touched each and every one of us in one way or another. My condolences to those who have lost loved ones; in the NHS we share in the sadness of those who have suffered a loss.

In response to the pandemic, NHSE/I was given legal directions over the CCG[1] commissioning functions by the Government in order to direct health services to meet the emergency needs, each system established an incident structure reporting to NHSE/I SE Region and the normal financial regime was adjusted so the majority of providers were on block funding. During the pandemic health and social care organisations made rapid changes to how services operated, the infection, prevention and control measures that were in place, and other adjustments made to ensure all patients with COVID needing hospital treatment could be treated. Much of primary care and outpatients moved to on-line with face-to-face contacts restricted to where essential to reduce the risk of spreading the infection. Changes also included introducing telephone triage in primary care so that GP practices talk to all patients on the phone first. Many patients have been provided with advice, care and prescribed treatment without needing to visit their practice.

For patients with the relevant technology, hospital appointments have been available using video conferencing so they can see, as well as speak to a doctor or healthcare practitioner. The OUH has undertaken 38,000 video appointments and Oxford Health 170,000 plus a significant number of telephone appointments have taken place. Primary care carried out over 1.8 million telephone consultations in 2020/21; almost doubling of the nearly 950,000 carried out in 2019/20[2].

New services were also brought online quickly to support people throughout the pandemic such as the 24/7 mental health line across Buckinghamshire and Oxfordshire; these services were set up in April 2020 and continue to support people young and old to access the advice and support they need for their mental health and emotional wellbeing. GPs worked quickly to set up dedicated clinics ('hot hubs') for patients with suspected COVID-19 to manage the risk of transmission to patients needing non-COVID related care. GP practices introduced remote pulse oximetry service for COVID positive patients in at-risk groups; these

[1] https://www.gov.uk/government/publications/the-exercise-of-commissioning-functions-by-the-nhs-commissioning-board-coronavirus-directions-2020?utm_source=fe01c604-789a-453e-90cb-16dd1c965200&utm_medium=email&utm_campaign=govuk-notifications&utm_content=immediate

[2] https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

measured a patient's blood oxygen levels and could alert clinicians to possible problems without the need for the patient to attend an appointment outside their home.

Some non-urgent services were stopped for a period of time during the first and then second waves of COVID-19 to focus on treatment of patients with COVID-19 and to prioritise people with urgent care needs; this included some screening and routine referrals for hospital care. At the same time, mostly due to lockdown, referral levels also fell significantly. Services were re-started after both waves as soon as possible but for some the new ways of working through COVID-19 have been maintained where these were felt to be better for patients. However, the infection controls and social distancing measures have meant we were not fully back to pre-COVID levels of planned care activity at the end March 21 although we will aim to exceed this as we move through 21/22. COVID-19 will continue to have profound impacts as we begin to reset the health system over the coming year and work our way through the backlog of patients who require non-urgent but necessary care and treatment. We recognise that this has led to changes in the numbers of patients experiencing long waits for treatment as shown in the table below:

	Numbers waiting 31 March 2021	Numbers waiting 31 March 2020
Over 62 days for cancer treatment (OUH)	144	147
Over 18 weeks for elective treatment	11,763	9,312
Over 52 weeks for elective treatment	4,075	22

Our response to the first phase of COVID-19 ensured that services, staffing and capacity could meet demand. Since that time, we have learned a lot; the Incident Control Centre (ICC) across the BOB ICS that was set up during Wave 1 was made more resilient with a greater number of staff for Wave 2 and this continues to be a conduit for cascading information, alerts and requests for action between NHSE and the three CCGs / place responses. The incident centre also facilitated and co-ordinated mutual aid requests for personal protective equipment (PPE) during the first wave in particular as well as other equipment.

At the end of 2020, the Government announced approval of the Pfizer BioNTech vaccine for use against COVID-19, followed by approval for the Oxford AstraZeneca vaccine early in January 2021. Well before the announcement, plans were underway across the BOB ICS for the roll-out of the vaccination programme, starting with our most vulnerable population. Vaccinations started in the BOB area on 7 December 2020 at the first hospital hub in Oxford, followed swiftly by our GP-led local vaccination service across all three CCGs on 14 December. Since then, more than a million vaccinations have been administered to the

population of the BOB ICS [3], with three quarters of those delivered by primary care. A huge thanks to the thousands of people across the NHS, local authorities and volunteers who have contributed to this success.

We are concerned that health inequalities have increased during the pandemic; we have addressed this head on through the vaccination programme with local health and care teams undertaking a range of communication, outreach and pop-up clinics to ensure good vaccination coverage in harder to reach groups. We are hoping that the trust we are building though this work will help as we move into 2021/22 and continue to work to identify inequalities and implement evidence-based interventions to reduce the gap. We also entered the year facing significant financial challenges. These became less acute with the financial regime that was put in place for NHSE to direct the COVID-19 response, but we will need to return to work on how to live within our means during 2021/22.

I joined as Accountable Officer mid-May 2020 as we were starting to come through the first wave. My year has been one working with three CCG Director teams, remotely, in unprecedented circumstances. The Governing Body operated separately through the first half of the year but with increased joint working and holding workshops together. Following the publication of the Integrating Care[4] engagement document and the White Paper[5] the Governing Body agreed the three CCGs would move to working in common for all core committees from 1 April 2021. As we move forward, we will establish a single management team over the three CCGs and ICS, first as an interim structure, then with substantive posts once NHSE guidance allows.

I want to extend my gratitude to colleagues within all three CCGs; many have worked in different ways, in different roles and well beyond their contracted hours. The pandemic triggered new ways of working – all CCG staff have been working from home for the past year and will continue to do so, potentially in hybrid form, for the foreseeable future. But as we move into 2021/22 I have been heartened to see colleagues step up to the challenge of the pandemic and am grateful for their efforts. All this at a time that is unsettling as we progress towards the development of a new, single, Integrated Care System.

Despite the challenges of the pandemic, we must not lose sight of the innovation and benefits which it has brought about. Going forward, we must also build on the collaboration across the three CCGs and the broader system of NHS and local authority partners, to integrate more where we can bring improved quality of care and benefits to patients. The year ahead will concentrate on the development of the ICS into the new statutory commissioning organisation for BOB and the implementation of place-based system recovery programmes, which will focus on inequalities and put the health, social and economic wellbeing of residents at its heart.

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[3] 900,000 people had received at least one vaccination dose as at 31 March 2021

[4] NHS England » Integrating care: Next steps to building strong and effective integrated care systems across England

[5] Integration and innovation: working together to improve health and social care for all (HTML version) - GOV.UK (www.gov.uk)

Summary of performance

Improving the health and wellbeing of people in Oxfordshire

The Health and Wellbeing Board (HWB) is a partnership between local government, the NHS and the people of Oxfordshire. It includes local GPs, councillors, Healthwatch Oxfordshire and senior local government officers. The board ensures that organisations across health and care work together to improve everyone's health and wellbeing, especially those who have health problems or are in difficult circumstances.

The board provides strategic leadership for health and wellbeing across the county and will ensure that plans are in place and action is taken to realise those plans. Along with the Joint Health and Wellbeing Strategy, the Board has a Prevention Framework for the county. Demand for health and care services is rising; nationally and locally there are workforce issues and financial resources are struggling to keep pace. The framework looks at how, across Oxfordshire, the NHS and local authorities together with the voluntary sector need to work differently, shifting to a more pro-active approach to:

- preventing illness and keeping people physically and mentally well, e.g. being active, breathing clean air, having social interactions
- reducing the impact of illness by early detection e.g. cancer screening, lowering blood pressure and cholesterol to help reduce the risk of stroke
- delaying the need for care and keeping people independent for longer

With the aims of:

- Improving quality of life by creating and promoting health and wellbeing
- Reducing health inequalities
- Saving our public services from the spiralling costs of treating avoidable illness and ongoing needs and improve the efficiency and wellbeing of the workforce.

While a considerable amount of work has been undertaken to deliver the Health and Wellbeing Strategy; on 30 January, the World Health Organisation (WHO) declared the outbreak of COVID-19 a Public Health Emergency of International Concern and then on 11 March 2020, declared the outbreak of a new type of Coronavirus, SARS-CoV-2, that causes COVID-19 respiratory disease, a global pandemic.

On 30 January 2020 the NHS declared a level 4 incident as part of its emergency preparedness, resilience, and response (EPRR) to the COVID-19 pandemic. This is an incident that requires NHS England National Command and Control to support the NHS response; at this time and during the past year 'all' NHS resources have been focused on our response to the COVID-19 pandemic.

BOB ICS response to the COVID-19 pandemic

The COVID-19 pandemic has spanned the entire NHS year and has led to profound and far- reaching changes to the way we all work and, as patients, to the way we access healthcare.

For the three clinical commissioning groups in Buckinghamshire, Oxfordshire and Berkshire West (BOB) 2020/21 has been a year of immense challenges from the moment the first case of the virus in the UK was officially announced on 1 February 2020.

The first phase of COVID-19 preparation and response ensured that services, staffing and capacity could meet the demands of the months ahead. Since that time, all partner organisations within the BOB area have been working together to help prevent the spread of infection, maintain critical services and protect the most vulnerable in our communities.

Continued partnership working, strong clinical leadership and the efforts of all colleagues have meant that challenges have been overcome wherever possible. For example, close collaboration has enabled the supply of Personal Protective Equipment (PPE) to be maintained, a programme of testing was rolled out, sufficient critical care capacity was secured for patients with COVID-19, and new ways of looking after patients with other conditions and illnesses were found.

By 23 March 2020, all CCG teams were expected to work from home in line with Government lockdown guidance. It was important to do everything possible to support front line services to care for patients. Many of our key colleagues in our partner NHS organisations and councils were leading their organisational response and needing to redirect resources internally. To support them we reviewed our demands on their time (e.g. meetings, information requests) to consider what was best for the system, which meant delaying, cancelling or doing things in a different way. Staff with clinical skills were also deployed to support front line services in community and hospital care including intensive care.

GP practices everywhere were provided with guidance to introduce telephone triaging to reduce footfall at surgeries and reduce the risk of spreading infection. Face-to-face patient appointments were available when clinically appropriate and under careful infection control measures. In addition, many practices were provided with additional IT equipment to allow more of their staff to work from home, thus protecting themselves and patients. Practices have also introduced eConsult, an advice and online appointment system that collects a patient's medical or administrative request and sends it through to their GP practice to triage and decide on the right care for the patient.

A detailed and effective joint communications strategy was implemented to ensure staff, patients and stakeholders kept up to date with a fast-moving situation. MS Teams was quickly adopted across the BOB CCGs, so staff were able to maintain close contact and share information, address current issues and plan for the months ahead. The virtual meeting space is now the norm for all CCG staff.

At the beginning of the lockdown, the main focus was to support more people to be discharged from hospital and to avoid admissions, so our acute hospitals had the space and resources to care for patients affected by COVID-19.

Many non-urgent elective operations and treatment were postponed, but urgent care including cancer continued. Some services were paused or were reduced to allow staff to be redeployed to support COVID-19. In the early months of the pandemic, there was a significant drop in the number of patients attending Emergency Departments, minor injury units and primary care and in the number of urgent referrals as well as an increase in the number of missed appointments. It is reasonable to assume there were fewer accidents happening at this time, but it is also the case that some patients were (and continue to be) fearful of using health care facilities or are putting off seeking help.

Several new ‘hot’ clinics to support patients with suspected or confirmed COVID-19 were opened across the BOB area to ease the burden on other healthcare facilities and free up hospital doctors to deal with more serious cases. The clinics were available for those people showing symptoms of COVID-19 but who did not need immediate hospital treatment.

GP practices were also focused on ensuring that all shielded patients (those at highest risk) were identified, supported and flagged on GP systems. They worked in partnership with local authorities and volunteer groups to ensure those patients had help with immediate needs including social care, safety concerns, urgent food requests and help with collecting medication.

As the second wave of the pandemic progressed, hospitals across the BOB ICS saw a very steep increase of COVID-19 positive inpatients from December 2020 to the first two weeks of January 2021. At the peak of the pandemic, hospitals across BOB were caring for 779 COVID-19 inpatients, 260 of whom were in critical care, which was three times more patients as our baseline capacity of 91 for critical care. Elective (non-urgent, planned) inpatient and day case activity was postponed, where appropriate, in order to focus on urgent and emergency care for COVID-19 and non-COVID patients and to enable the redeployment of staff to treat this cohort of patients.

Learning from the first wave meant that an Incident Control Centre (ICC) was set up across the BOB ICS in time for the second wave. The ICC was the main point of contact for the NHS England (NHSE) regional team for COVID-19, winter pressures and for the EU Exit. It was and continues to be a conduit for cascading information, alerts and requests for action between NHSE and the three CCGs responses. It has also facilitated and co-ordinated mutual aid request for personal protective equipment (PPE) during the pandemic and other equipment. It has overseen the BOB PPE warehouse, which enabled system partners to access PPE when there was shortfall or supply issues. It has also overseen and coordinated the roll out of the COVID-19

vaccine programme across the three CCGs. It was and continues, to be the link to all Directors of Public Health for system wide outbreak management. The ICC will continue its role as we enter 2021/22.

Oxfordshire's response

During the last year OCCG has been working close with all NHS providers and the Local Authorities to respond to the challenges of the pandemic. The breadth and depth of system partnership working over this period has strengthened our ability to respond for the benefit of our local communities.

During March and April 2020, the NHS in Oxfordshire refocused capacity to ensure that patients with COVID-19 could be cared for; supporting discharge of all medically fit patients; increasing critical care capacity; establishing separate wards; developing a primary and community service response that separated potential COVID-19 patients from other patients; establishment of a 24/7 mental health helpline.

In addition, all parts of the NHS rapidly introduced remote consultations either via phone or video wherever possible; this is now widespread in mental health and learning disability services, primary care and hospital outpatient services.

While the NHS has remained open throughout (albeit in a different way) locally as well as nationally, we saw a decrease in attendances at A&E, emergency admissions and referrals for cancer, mental health and other conditions needing urgent attention. We worked together across Oxfordshire, to support the national 'Help us help you' messaging to ensure that the public continue to seek medical help when they need it during the COVID-19 pandemic.

Since the beginning of the pandemic, we have continued to support the national campaigns and promote advice including the importance of handwashing and how to socially distance. This is ongoing and continues to be important as restrictions begin to get lifted. This has been promoted both online and offline through the media, digital media, key community contacts and information has been made available in different languages.

Supporting care homes to provide high quality care to some of our most vulnerable residents during the COVID-19 pandemic has been essential. Health and social care partners across Oxfordshire worked closely with care home providers to develop and deliver a support plan for homes, their staff and residents. The focus of the work included preventative and proactive support for all care homes to ensure that education and understanding regarding care for residents, in line with national guidance, is in place; and focused support work with care homes which may have experienced outbreaks or particular challenges.

The need to respond so quickly has radically altered the way patients access services; this may be through new routes (phone first/total triage and virtual consultations) or needing to attend in different locations as COVID and non-COVID patients are kept separate.

OCCG worked with local GPs to establish a COVID-specific response across the county, known as the CALM service. This saw the opening of three clinic sites for patients with suspected or confirmed COVID who were finding it difficult to manage their symptoms at home. The clinics, in Banbury, Oxford city and Wallingford (in the south), are supported by a visiting service for those patients unable to travel safely. Since the service has been fully open it has had around 11,000 contacts with patients.

GP practices in Oxfordshire introduced remote pulse oximetry for COVID positive patients in at-risk groups. This measures a patient's blood oxygen levels and can alert clinicians to possible problems without the need for the patient to attend an appointment outside their home. Work was also started to increase levels of Learning Disabilities and Severe Mental Illness health checks and improve ethnicity recording in recognition of the numbers of people seriously affected by COVID in these groups.

In addition, diabetes and obesity are significant risk factors for serious illness if the patient is infected with COVID-19. Not long after the start of the pandemic, a dedicated hotline was set up by healthcare partners to help people with diabetes. Teams at OCCG, OUH and Oxford Health designed the service for patients in need of urgent clinical advice will give reassurance and to help prevent admission to hospital.

A 24 hours a day, seven days a week mental health helpline was launched by Oxford Health and out Oxfordshire Mental Health Partnership (OMHP) to provide advice in Oxfordshire. The round-the-clock helpline made it quicker and easier for people to get the right advice and support they need from mental health professionals.

As the first wave of the pandemic receded in summer 2020, primary care saw a return to pre-COVID demand for appointments, which have continued to be telephone triaged, carried out online, via video link, and face to face.

Overall primary care consultation levels had recovered to almost pre-pandemic levels by September 2020. As in the previous years there was a reduction in November and December from a peak in October associated with the flu campaign. However, February 2021 activity exceeded February 2020 by around 28,000 consultations across the BOB ICS.

In Oxfordshire, telephone consultation numbers remain much higher than pre-COVID but there has not been a significant increase in online consultations. Around 50% of consultations were provided face-to-face in December 2020 compared to 69% in February 2020. This is an increase from a low of 35% in April 2020. These trends are replicated across the three CCG areas.

COVID-19 Vaccination Programme across the BOB ICS

In December 2020, as cases rose again significantly across the UK, the Government announced approval of the Pfizer Biontech vaccine against COVID-19, followed by approval for the Oxford Astra Zeneca vaccine early in January 2021.

The BOB vaccination programme was established at the beginning of November 2020. The team have been responsible for working with the NHS South East Region, provider organisations and local authority colleagues to deliver vaccinations to the population of BOB in accordance with the Joint Committee on Vaccination and Immunisation (JVCI) advice.

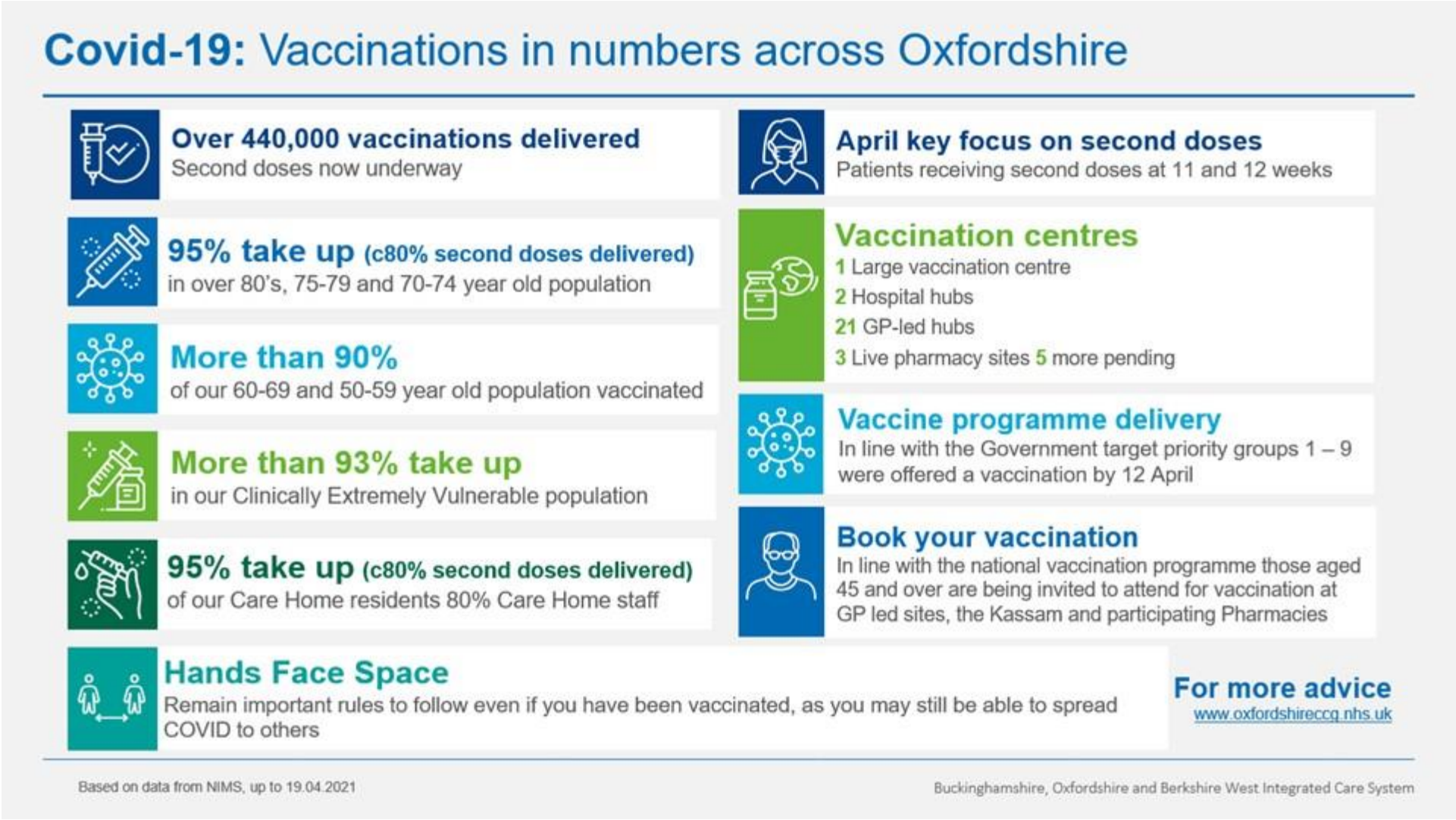
The initial stages of the programme focused on the planning and mobilisation of staff to deliver the vaccine programme. That work has continued through roll-out, adapting as the vaccination stock has become available and the deadlines for vaccination of priority groups is brought forward. This will continue as further vaccine becomes available and vaccination sites change.

Thanks to the hundreds of NHS workers, local authority staff and volunteers involved across the three CCG areas by 31 March 2021, we had achieved:

- 900,000 people had received at least one vaccination dose
- 100% of care homes had been visited
- All frontline health and social care workers had been offered the vaccine
- Nearly 95% of our population aged 60+ vaccinated with at least one dose
- More than 90% of our clinically extremely vulnerable had been vaccinated
- More than 80% of over 50s had been offered a vaccination appointment

At the end of March 2021, we were on track to achieve our target of offering a first dose of the vaccine to all nine priority groups (as directed by the JCVI) by 15 April 2021. Current projections see us completing all first doses for adults aged 18 and over by July 2021 and second doses by the end of September / early October. This has been a huge logistical challenge being delivered at the same time as managing the increased pressures on health and care services caused by the pandemic.

Delivering the vaccination programme in Oxfordshire



In Oxfordshire, OCCG, our NHS provider partners, and local authorities began the enormous task of rolling the biggest ever mass vaccination programme in the UK's history. The Oxfordshire Vaccination Delivery Board was set up to oversee the programme and includes colleagues from OCCG, our provider Trusts, Public Health, county, city and district councils and the Oxfordshire Association of Care Providers. It has overseen the establishment of two hospital vaccination hubs, 21 GP-led local vaccination sites and a mass vaccination centre at the Kassam Stadium in Oxford. Towards the end of March three local pharmacies in Banbury, Carterton and Wantage were authorised as vaccination sites and started delivering the vaccine to local people.

All this has been achieved at the same time as supporting GP practices to balance the vaccination roll-out with 'business as usual' responsibilities. As we move into the next stage of pandemic recovery, we will work together as an Oxfordshire system to build on and embed the innovation and new ways of providing services developed through our COVID response.

Tackling urgent care pressures in the county

The effects of the pandemic on the health system made it even more important for health and social care professionals across the Oxfordshire system to work together to deliver responsive and joined-up services throughout the winter season. The winter team's priority was to ensure people who needed medical treatment were able to access services to get the care they needed.

Local people were again encouraged to have a winter plan, look after themselves and stay healthy, and to use healthcare services in the most appropriate way. Emergency Departments are for genuinely life-threatening conditions, otherwise local pharmacies, minor injuries units, or GP were signposted together with NHS 111 which advises and directs patients to the best place for care.

People were urged to have a winter plan for themselves and their family to keep as well as possible, what they could do if they became unwell, and how to look after more vulnerable neighbours and friends. A significant message was the importance of the flu jab for vulnerable people.

During 2020/21 GP practices found new and innovative ways to deliver flu clinics to those patients eligible for the free flu jab, to ensure safety during the pandemic. Overleaf shows the flu vaccine uptake compared to the previous year; it shows above the national average in all categories and an increase of uptake in all but pregnant women from the previous year.

	Over 65's 2020/21	Over 65's 2019/20	At risk 2020/21	At risk 2019/20	Pregnant 2020/21	Pregnant 2019/20	2yrs 2020/21	2 yrs 2019/20	3 yrs 2020/21	3 yrs 2019/20
% vaccinated	84.3%	76.3%	58.8%	48.6%	50.5%	53.2%	67.9%	56%	69.1%	55.6%
No registered	125,265	128,118	91,804	89,884	9,013	8,568	6,939	7,648	7,054	8,039
No vaccinated	105,630	97,775	54,085	39,281	4,555	4,560	4,709	4,283	4,871	4,469
% vaccinated nationally 2020/21	80.9%	72.4%	53%	44.9%	43.5%	43.7%	55.3%	43.4%	58%	44.2%

As pressures in local hospitals grew, especially during the winter period and the second wave of the pandemic, families were reminded of their pivotal role in making it easier for older people to get home when they are ready to be discharged from hospital. The 'Home First' initiative, involving a single health and social team, helps patients leaving hospital to identify what support they need to regain independence and confidence.

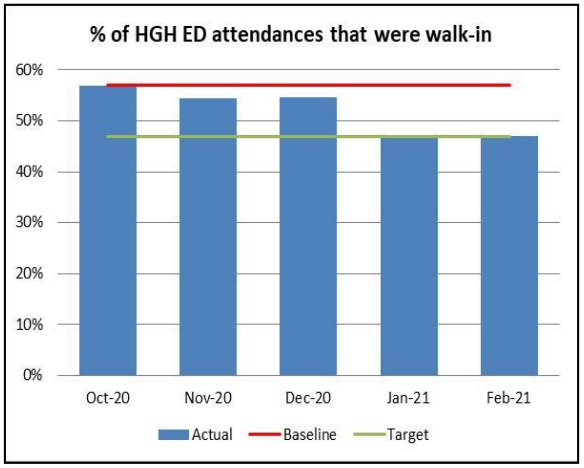
Just 10 days in hospital can lead to 10 years' worth of aging in the muscles of somebody over the age of 80. Oxfordshire's highly skilled community teams worked to support older people when they get home by continuing nursing, therapy and rehabilitation needs.

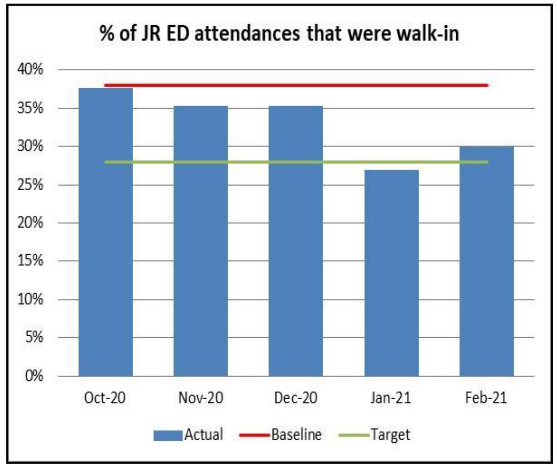
In November 2020, a new initiative was launched across the BOB ICS to encourage residents to contact NHS 111 First if they are thinking of attending an Emergency Department (ED). NHS 111 is the national system that people can contact if they need clinical advice – either by phone or online. The new initiative means that people who need clinical advice but aren't in a life-threatening emergency are encouraged to contact NHS 111 first before attending their local Emergency Department (ED). They are then assessed and, if appropriate, booked into their local ED. However, if it is more appropriate for them to receive clinical help and / or advice elsewhere, they are advised on:

- how to self-care if required
- visiting their local pharmacy, dentist, optician, or their own GP for help
- visiting a local Minor Injuries Unit

NHS 111 First was designed to improve outcomes and experiences for patients in healthcare settings, to help EDs maintain social distancing therefore reducing the risk of COVID-19 transmission as well as the transmission of seasonal illnesses like flu and colds. The service also ensures that people receive the right care in the right place.

In February 2021, 65% of attendances at the EDs at the John Radcliffe Hospital and Horton General Hospital were planned attendances; of these 16% were from NHS 111, 10% form GPs and 39% from ambulance arrivals.





Cancer waiting times

In recognition of the COVID-19 pandemic, cancer systems have been under significant pressure to deliver treatment for all patients. This has included systems across the BOB ICS.

The OUH, along with other hospitals across BOB, has been working with the Thames Valley Cancer Alliance (TVCA) in the development of a recovery plan for cancer services with the aims of:

- Reducing unmet need and tackling health inequalities, working with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels
- Managing the immediate growth in people requiring cancer diagnosis and/or treatment returning to the service
- Thereby reducing the number of patients waiting for diagnostics and/or treatment longer than 62 days on an urgent pathway, or over 31 days on a treatment pathway, to pre-pandemic levels, with an immediate plan for those waiting longer than 104 days

See page 35 for performance data on cancer waits and treatment times.

C the Signs

C the Signs is a digital tool that uses artificial intelligence mapped with the latest evidence to identify patients at risk of cancer. Covering the entire spectrum of cancer and cross-referencing multiple diagnostic pathways, C the Signs can identify which cancer or cancers a patient is at risk of and the most appropriate next step. It can be used as a safety netting tool in primary care.

In October 2020 Oxfordshire OCCG started a pilot to trial C the Signs in the county; 57 practices have signed up. Data is being collated and an evaluation will be completed later in the year.

Cancer Care Review (CCR) Implementation Support Scheme

The CCR Implementation Support Scheme is part of the Thames Valley Cancer Alliance's five-year delivery plan to improve outcomes for people with cancer by 2020 and it aligns with the national cancer strategy 'Achieving World-Class Cancer Outcomes (A Strategy for England 2015-2020)'.

The scheme is looking for all GP practices to adopt the standardised CCR template and undertake a second cancer care review with each patient (the first cancer care review is part of the primary care Quality Outcomes Framework).

Across the BOB ICS, the Buckinghamshire and Oxfordshire schemes went live in December 2020. An engagement event was held with speakers from primary and secondary care, and the voluntary sector. More than 80 primary care clinicians joined the event, which is available to watch here. In Berkshire West, year one of the scheme closed in October 2020 with 457 reviews carried out by primary care. The launch of Year 2 of the scheme was delayed to April 2021 to support primary care to set up COVID-19 vaccination services.

SCAN Pathway

OCCG and OUH won Cancer Care Team of the Year at The British Medical Journal Awards 2020 for the innovative suspected cancer (SCAN) two-week pathway run at the Churchill Hospital in Oxford. The suspected cancer SCAN two-week pathway is specifically designed for patients with "low risk but not no risk" cancer symptoms.

Patients are referred to the service by their GP if they have symptoms such as unexplained fatigue or unintended weight loss. If they meet the SCAN pathway criteria, they undergo a CT scan and blood tests. If cancer is detected they are referred on to the appropriate consultant so they can start treatment quickly.

The judges said this outstanding project was "a great step forward in fulfilling the need for better pathways for patients with non-specific but worrying symptoms". They said the programme showed ‘great cooperation between primary and secondary care and the use of data’. The pathway has already made a big difference for those patients with suspicious presentations who would have had a cancer go unfound, or found late, without this work.

The Oxford Radiology Research Unit (ORRU) and the Radiology department at the Churchill Hospital are running the SCAN pathway which involves:

- rapid access to Computed Tomography (CT) scanning
- laboratory tests (blood and faeces tests)
- any further tests if needed

The clinical team work closely with statisticians and researchers at the University of Oxford to continue to evaluate and improve the service, and to develop new types of blood tests for earlier cancer diagnosis in patients with non-specific symptoms.

More than 2,513 patients have been scanned in the period up to 12 April 2021 from the service’s launch in 2018. A total of 216 patients have received a confirmed cancer diagnosis from the pathway – an 8.6% conversion rate – and have gone on to receive the care they need.

Elective care

Early in the pandemic, routine referrals and elective operations and treatments were paused across the BOB ICS in line with national guidance from NHS England & NHS Improvement (NHSE&I). In Oxfordshire, the OUH stopped receiving routine referrals from GPs in order to focus on the treatment of patients with COVID-19. During that time, urgent and suspected cancer referrals were still accepted and the OUH continued to carry out urgent and emergency treatment.

As the levels of COVID-19 declined over the summer of 2020, OUH reinstated services to support the vast majority of routine referrals. However, for a small number of specialties where demand was greater than the capacity at OUH, which would result in long waits for treatment, patients were seen and treated elsewhere. Plans varied from specialty to specialty; ranging from opening up referrals to OUH in the near future, to continuing to work with our healthcare system colleagues to provide alternative locations for patient care within the independent sector, and with other NHS providers.

To support the resumption of elective care the OUH has worked OCCG and other NHS partners as well as the independent sector partners so patients could be seen as soon as possible. They also

- Maximised the use of peripheral clinic capacity because updated Infection Prevention and Control guidance has reduced the number of patients who can be seen safely in hospital outpatient clinics, due to the need to maintain safe social distancing in light of COVID-19
- Ran outpatient clinics 7 days per week in some specialties
- Increased the use of independent sector outpatient capacity for some specialties
- Increased the number of patients who could have 'virtual' appointments eg video consultations, telephone appointments etc (throughout the COVID-19 pandemic, the OUH continued to offer outpatient appointments both face-to-face and virtually with over 38,000 appointments delivered via video, and 127,579 delivered over the phone)
- Worked closely with partners across BOB ICS to identify capacity in neighbouring acute hospitals

Recovery work commenced in August 2020; however, this was paused again as the second wave of the pandemic progressed with a steep rise in the number of COVID-19 positive patients admitted to Oxfordshire hospitals in January (88 on 18 December to 317 on 18 January). Hospital staff were caring for more than twice the number of COVID-19 positive patients than at the peak of the first wave of coronavirus in Spring 2020. To respond to this unprecedented situation, OUH had to focus on urgent and emergency care, including cancer care, and redeploying clinical staff to work in COVID-19 areas in particular.

2021/22 will concentrate on the restarting of elective services and recovering from the impact of pandemic which has presented an extraordinary challenge to the NHS and our local communities, which we have never seen in our lifetime. The impact includes a significant increase in the numbers of patients experiencing long waits for treatment. Despite this some work has continued to redesign and deliver services in a different way to meet the challenge of the pandemic:

New Community Gynaecology Service for Oxfordshire: During 2020/21 a Community Gynaecology Service was established in Oxfordshire to meet the growing demand for gynaecology care, to provide care closer to home and to reduce the number of unnecessary referrals being sent to secondary care. Many patients can be treated in the community, which protects the specialist hospital service and avoids unnecessary trips to hospitals – this has become even more important during the COVID-19 pandemic.

The community gynaecology service started with a pilot in Oxford City and North Oxfordshire in January 2020, with the service beginning expansion across the county in November 2020. The outcome of the pilot was that 50 per cent of patients were diverted from referral on to secondary care following triage by the community service. The service is triaging all gynaecological referrals and continues to have good results.

Year of Care and Personalised Care: Work towards Personalised Care has continued throughout the last 12 months, with sessions being completed virtually. The pilot study for 'Making Every Contact Count' was delivered to different organisations including the volunteer sector. 'Train the Trainer Making Every Contact Count' was delivered to County Council customer services and the volunteer sector. Motivational Interviewing was delivered to Social Prescribers.

Blood Pressure Monitoring: OCCG has started a project to enable Blood Pressure monitors at home to be provided to clinically vulnerable patients with uncontrolled hypertension. The initial target of this Keep the Pressure off project is for those people who need them and who live in areas of deprivation. Monitors have already been given to several GP practices in Oxfordshire and will continue to be rolled out in the coming months.

Improving diabetes care and prevention: A multi-organisational team including clinicians and managers from OCCG, OUH, Oxford Health and the South Central & West Commissioning Support Unit, developed a Diabetes Dashboard, which presents diabetes care and health outcomes data monthly for the Oxfordshire diabetes population. It presents data at county, PCN and GP practice level, thereby providing regular insight into Oxfordshire diabetes population health.

The Dashboard has subsequently been used in regular visits in GP practices and PCNs by Diabetes Consultants and Community Diabetes Specialist Nurses to develop supportive multi-disciplinary working and joined up care across primary, community and secondary care that improves outcomes for people with diabetes.

The implementation of the Dashboard and multi-disciplinary collaboration has played a significant role in improving the care of people with diabetes within Oxfordshire as is evidenced in the National Diabetes Audit (NDA). It has also been shortlisted for a prestigious Health Service Journal Value Award in the 'Diabetes Care Initiative of the Year' category.

Supporting children and young people with their mental wellbeing

Oxfordshire's Children and Young People Mental Health service (CAMHS) was fully operational throughout 2020/21 and quickly set up digital support at the start of the pandemic – with face-to-face appointments for those young people who are unable to access online help. The digital approach is being formally evaluated for clinical effectiveness.

As part of the efforts to support young people and their families during the pandemic, the CAMHS pages on the Oxford Health NHS FT website hosted a suite of specially created self-help videos to explore and understand emotions created by lockdown, social distancing and COVID -19. The animations, created by Professor Paul Stallard, the Oxford Health CAMHS psychologist, provides information on a range of feelings, explores what is normal and provides practical solutions and work sheets which can involve the whole family.

Mental Health Support Teams into schools offered online support to children via newsletters, guides and online assemblies and support sessions, all of which were well received. The service is currently working across the BOB ICS with mental health commissioners to jointly recommend a pipeline of future services.

OCCG worked with Oxfordshire County Council and CAMHS partners to deliver a national training package for education staff – Wellbeing Return to Schools. This training aimed to provide schools and colleges with support and tools to enable staff to respond to the emotional impact of the pandemic on their pupils and colleagues.

OCCG and its partners were successful in bidding for funding for the national Keyworker pilot to deliver the NHS Long Term Plan ambitions. By 2023/24 children and young people with a learning disability, autism or both with the most complex needs will have a designated keyworker.

Initially, keyworker support will be provided to children and young people who are inpatients or at risk of being admitted to hospital. Support will also be extended to the most vulnerable children with a learning disability and/or autism, including those who face multiple vulnerabilities such as looked after and adopted children, and children and young people in transition between services.

The Children's Eating Disorder service has shown some improvement over 2020/21. OCCG has achieved the urgent standard (seen within 1 week) in the last three quarters. Performance against the national standard for routine referrals was significantly challenged in quarter four. Additional investment was made in 2020/21 and more is planned for 2021/22. Remedial measures through 2020/21 included redeployment of staff. Recovery is anticipated in 2021/22 as locum staff recruitment have now been recruited to support recovery.

Delivery of mental health services for adults

Throughout the past year work has continued to develop mental health services to support mental wellbeing and improve outcomes for people suffering from mental health conditions.

As part of the NHS Long Term Plan, the Community Mental Health Framework is a new way of working that aims to improve joining up mental health services so that GPs, mental health teams and other support organisations in the community work better together and improve the experience of people with significant mental health conditions using services. Part of this includes a three-year investment plan which will be rolled out across the country and centre around PCN neighbourhoods, starting in the summer of 2021 in Banbury, SE Oxford City and Abingdon. OCCG have worked with people who use services, their families, third sector organisations and communities; working together to shape what is needed and ensure they continue to be part of the delivery going forward.

Similar to CAMHS, mental health services for adults and older people were fully operational throughout 2020/21 and quickly set up digital support at the start of the pandemic. There was also investment and expansion of mental health crisis services in the community, such as the extension the SafeHaven hours in Oxford City, and increasing capacity in the Crisis Home Treatment team alongside the introduction of a 24/7 mental health helpline to provide people with mental health advice during the pandemic.

The round-the-clock helpline aims to make it quicker and easier for people in Oxfordshire (& Buckinghamshire) to get the right advice they need for their mental health and emotional wellbeing. The services is for all ages including children and older adults and operates 24 hours a day, seven days a week for people who need mental health care when their situation is not life threatening.

During 2020/21 a new Step Down Housing initiative was successful in providing short-term housing following hospital discharge for people who may become homeless and having housing difficulties, and included housing workers embedded in hospital wards to support staff to facilitate quicker discharge when people were medically fit and linking people with support in the community.

The county's improving access to psychological therapies service TalkingSpace has been integral to local system planning to deliver an integrated post COVID-19 group programme of supporting access to therapies.

Across the BOB ICS work continues to support online booking systems, long COVID training and supervision, in reach work for black ethnic and minority ethnics (BAME) communities, a feasibility study for 'Live Chat' and a marketing campaign to reach more older adults and BAME communities to improve their mental wellbeing.

Developing services and support for people with learning disabilities

The BOB ICS is developing a three-year delivery plan for people with learning disabilities and / or autism. The plan aims to improve outcomes for people with learning disabilities and / or autism; tackle the causes of morbidity and preventable deaths, reduce the waiting time for specialist support and work with people with learning disabilities and / or autism to improve their health and wellbeing.

To help us do this in Oxfordshire, we have worked closely with both our primary and secondary care providers to improve the quality and uptake of Annual Health Checks for people with Learning Disabilities. We were successful in achieving 72%, exceeding the target of 67% which was set by NHS England. This has meant that during the past year of the pandemic, we have ensured our LD population continued to receive essential ongoing care, including flu and COVID-19 vaccines.

In August 2020 we launched a new OCCG Autism Awareness Card. This scheme has been backed by Autism Family Support Oxford (AFSO) and Kingwood, a local autism charity. Both charities have worked with medical professionals and Thames Valley Police to raise awareness of the identity cards. The card is free for anybody on the autism spectrum and includes simple practical advice and emergency numbers for contacts, family members or carers.

Medicines optimisation

The safe and effective use of medicines is an essential element of healthcare. Medicines optimisation teams, which include pharmacists, work across the BOB ICS supporting clinicians, patients and carers in making decisions about which medications to use for the best possible outcomes.

The teams have and continue to be closely involved in COVID-19 related work supporting end of life care, the extension of services provided by community pharmacies, support to care homes, accreditation of GP led primary care network COVID-19 vaccine sites and supporting vaccine clinics. In addition, the teams regularly published lists of 'frequently asked questions' on CCG websites to keep prescribers up to date on changes and recommendations during the pandemic. Staff were also redeployed to work in the ICS's Incident Control Centre[6].

Alongside this, in 2020/21, OCCG's medicines optimisation team continued to support appropriate prescribing across Oxfordshire, including the review and implementation of guidelines, collaborative work with providers, the introduction of new pathways and the review of governance arrangements.

Improving Quality

OCCG is responsible for ensuring continuous improvement in the quality of services it commissions in connection with the prevention, diagnosis or treatment of illness. Improving the quality of healthcare provided to people in Oxfordshire is at the heart of what we do. We work together with our partners to improve patient experience, improve the quality of services and learn from incidents to reduce the risk of them happening again. OCCG and partners do this in many ways; below gives a flavour of some of the work undertaken to improve quality.

During 2020/2021 the Quality Team continued to ensure high quality care for the population of Oxfordshire as well as adapting to support the needs of the pandemic. Members of the CCG's Quality team were redeployed to support the incident response, including redeployment to the front line. The team also developed and staffed the Oxfordshire Incident Control Centre in wave

[6] The Incident Command Centre is the BOB wide team that supports health and social care partners and their staff to work together and pool resources during the pandemic

one of the pandemic and continue to support the BOB wide Incident Control Centre in subsequent waves.

A role of the Patient Safety Team at OCCG is to monitor and review feedback from primary care on a weekly basis. This GP feedback continued throughout the pandemic, including at peak waves and national lockdowns – with a focus of addressing immediate safety concerns responses during particularly busy periods. Due to the many queries OCCG received regarding the COVID vaccination programme the Patient Services Team worked with OCCG Communication and Primary Care teams to develop a FAQs section for the website which also enabled Patient Services to provide an early response. The FAQs were updated as the vaccination progressed.

Another core duty of the Patient Safety Team is to review Serious Incidents (as defined in the Serious Incident Framework, 2015) from all our providers – the focus is to act as a critical friend to providers and services to ensure that the issues identified in a Serious Incident are addressed with robust measures to prevent future patient safety incidents. There has been an increase in Serious Incidents reported in 2020/21 (136) compared to the 2019/20 financial year (111) – the increase has been significantly impacted by COVID-19 and some of the associated harms caused by the virus and its impact upon patients and health services. These incidents are reviewed and lead directly to changes in practice which improve patient safety. An example of this was an incident being reported of a pressure ulcer on a patient in hospital; this lead to the ward implementing 'safety huddles' with the entire multi-disciplinary team and the use of an new application to allow staff to upload images of pressure injuries, leading to a significant improvement project within the whole ward.

Before the pandemic OCCG and the OUH already had a system in place to establish whether patients who were waiting a long time for their treatment came to harm as a result of the long wait. Each patient who waited in excess of 52 weeks for treatment or over 104 days for cancer treatment were reviewed to establish whether harm had resulted and to understand what could have been done differently. Where necessary treatment was expedited. If harm was identified, then a patient safety incident was declared and thoroughly investigated. Wherever possible the patient was involved in the discussion about whether harm had resulted. Where harm was identified the patient was informed. The impact of the pandemic means that the numbers of patients with long waits has increased many times over. This meant that it was no longer possible to review each patient individually; specialties looked at cohorts instead. The system introduced during the pandemic has meant that patients have been prioritised so that harm has been minimised.

OCCG's quality team played a key role in the partnership group supporting care homes during the pandemic over the past year. Membership of the group was wide ranging including representatives from Care Homes, Public health, Oxfordshire County Council, Primary Care and NHS Safeguarding. The group managed any concerns raised around care home and residents. Following the identification by care home managers and workers that national webinars were not providing the local support required, OCCG initiated the first webinar for Oxfordshire Care Home staff to support their work during the initial phase of the

pandemic. Infection prevention and control (IP&C) support was a key component of the support required which included both training using virtual platforms to Care Home staff, monitoring to ensure all Care Homes were up to date with recent IP&C training and follow up directly with Care Homes where assurance was not provided.

During the height of the pandemic where a home was in difficulty due to staffing issues the CCG working with local partners and providers to ensure appropriate support was provided to a home. The Quality team and Primary Care team alongside OUH and OHFT developed hospital admission/discharge plans to ensure safe practice preventing the further spread of COVID-19. The success of the integrated approach to Care Home management though COVID-19 will continue to support winter planning and any further outbreak management e.g. flu for 2021/22

Addressing health inequalities

Work continues across Buckinghamshire, Oxfordshire and Berkshire West to reduce health inequalities; a BOB wide equalities group has been established with representation from all three areas to do more to tackle inequalities. The main aim of the group is to identify inequalities and implement evidence-based interventions to reduce the gaps by working with our local communities and ensure we share learning and best practice across the ICS on local interventions that make a difference. It will also develop an equalities strategy to help deliver the population side of NHS South East England's 'Turning the tide'; a strategy developed in response to the challenges faced by black and ethnic minority communities during COVID-19. While developed in response to COVID-19, the strategy has informed the South East region's wider approach to reducing racial inequalities in health.

There is also a specific piece of work across BOB that aims to promote confidence in the COVID-19 vaccination programme and enable optimal vaccine uptake. The team leading this work is reviewing and monitoring COVID-19 vaccine uptake data across BOB to identify groups with the lowest levels of vaccine uptake, they are working to promote vaccine uptake and reduce inequalities by working with local communities to increase confidence, increase convenience (access) and reduce complacency where there are low levels of COVID-19 vaccine uptake.

In Oxfordshire, we have a have a multi-agency approach to reducing equalities. During COVID-19 considerable work has been undertaken to reach black, ethnic and minority groups and ensure information on the pandemic, outbreak management and vaccine programme are made available in different languages and formats which make them more accessible including:

- Self-recorded videos from BAME members of staff to stay safe and encourage uptake of the vaccine used via social media
- Videos in other languages (Arabic, Bengali, Farsi, Hindi, Punjabi, Slovakian, Tamil, and Urdu, Swahili and Polish)
- Community events have been held with a many Muslim communities via their mosque, women's refugee group, black minority, Asian (Pakistani, Bengali, Indian), Polish and Albanian communities to find out what concerns they have around the COVID-19 vaccine and to offer accurate information and reassurance; these have included local GPs.

- Social media (Twitter and Facebook) has been used and shared across to promote staying safe during the pandemic, encouraging people to stick to lock down rules and to encourage people to take up their invitation to have the COVID-19 vaccine and tackle any myths around the vaccine, including to women who might be concerned about fertility
- We have developed animations to support the uptake of the vaccine and dispel myths – this was developed from feedback from local communities; this has been translated into Polish, Urdu and Swahili.

Another significant piece of work included the development of an outreach visiting service, a collaboration between the local district and city councils with the NHS to identify people in the priority groups for the COVID-19 vaccine who have yet to respond to their invitation for the vaccine. The service launched in February 2021 and aims to help support those people if they want to have the jab. There are a range of reasons why people may have not arranged a vaccination - from difficulties in booking an appointment or arranging transport, to hesitancy or misunderstandings about the vaccine.

Outreach workers from the city and district council community hub teams of the city and district councils across the county had visited over 750 addresses of registered patients in the priority groups 1-9, by the end of March 2021, who have not had a COVID-19 vaccine and offered them support to get an appointment if they want one.

Engaging the public and local communities

OCCG believes that communicating and engaging with its local population is key to achieving its vision. The organisation is committed to putting the patient first and applying the principle of 'No decision about me without me' in its commissioning approach. OCCG uses the NHS England Principles for Participation to guide its public involvement activities.

Our Communication and Engagement Strategy 2020/21 sets out the overall strategy for engagement. The methods used for engagement vary depending on the activity and who we need to talk to. The population of Oxfordshire is diverse and each community has different needs. It is important for us to understand this diversity to ensure health services are planned properly and provide equity in terms of access, experience and outcomes for everyone.

OCCG looks carefully at each project and considers the scale, who should be involved and what methods to use. For bigger projects, it is likely that the engagement will involve more people and require some publicity to ensure those with an interest are aware of the opportunity to get involved. For smaller pieces of work, it might be possible to work with a patient group or individuals in a targeted way.

During the past year as this report has already shown, the COVID-19 pandemic has had a fundamental impact on the NHS across the country and all resources, including communications and engagement staff, were diverted to supporting frontline

services in continuing to support patient care. Information and guidance to support clinicians working across the local NHS needed to be refreshed and updated as guidance was issued.

In addition, the need to protect patients and staff from infection meant that face-to-face methods of engaging patients and the public were not used and this continues to be the case. This includes meetings in public which have moved to be organised online and require members of the public to have access to the internet to be able to participate.

While the pandemic has meant fewer engagement projects, below outlines a couple of examples from the past year.

Young people accessing primary care: OCCG worked with two schools in Oxfordshire to understand young people's views on access to primary care, particularly during the pandemic and the drive for GP services to be remote and digital. Young people are frequent users of primary care services, but their voices are rarely heard providing feedback. OCCG worked with year 12/13 students in Oxford City and asked for students' help approaching their peers for their views. We had face-to-face meetings with three groups (in a COVID-secure setting), and two of these co-designed and co-produced projects which gained high participation from their peers. The findings have been shared with pediatricians, CCG colleagues and adolescent health specialists, and will be used to inform signposting and help young people with accessing services.

Using eConsult: In response to COVID-19 health and social care organisations have made rapid changes to how services are accessed and delivered. Many of the changes have been intended to reduce the face-to-face contact which in turn reduces the risk of spreading the infection. Changes have included introducing telephone triage so that GP practices talk to all patients over the phone first. Many are then provided with the advice and care they need without needing to visit the practice. For patients with the relevant technology, appointments have been available using video conferencing so that they can see, as well as speak to the doctor. In general practice the use of eConsult, an advice and online appointment system, was introduced. eConsult is a form-based online consultation platform the collects a patient's medical or administrative request and sends it through to your GP practice to triage and decide on the right care for the patient. We undertook an analysis of patient feedback from those patients using the system in April and July 2020. The feedback was shared with the CCG's primary care team to support improvements in the use of the system.

How does OCCG manage its money?

The national planning process for 2020/21 was put on hold in March 2020 as part of the actions taken to enable the NHS to focus on the immediate emergency response to the pandemic. A new financial regime was introduced in order to simplify payment arrangements and to ensure sufficient cash flow to providers to enable the response.

This was initially intended to cover the first four months of the year but was subsequently extended to the first six months. The second six months of the year were covered by revised arrangements designed to pass more control back to local systems but

retaining a block payment approach for NHS providers. Expenditure for the first six months was fully funded by NHS E meaning that the CCG broke even over that period. In the second six months the CCG achieved a small surplus of £236k, which means that the CCG delivered against its financial plan for that period.

OCCG brought forward a cumulative historic surplus of £23.4m into 2020/21 none of which was requested to be utilised (drawn down) in the year. The surplus achieved in 2020/21 will be added to the historic surplus and will be carried forward into next year.

For the financial year 2020/21, OCCG's total funding was £1,087m. Of this, £1,070.1m was allocated for healthcare programmes and £13.2m for the CCG's running costs as reflected in the table below which summarises our budget (plan) and actual expenditure for 2020/21:

	Budget M1 to M12 £'000	Actual Month 12 £'000	Variance Month 12 £'000
Acute	523,043	527,753	4,695
Community Health	96,761	94,716	(2,029)
Continuing Care	105,698	104,931	(767)
Mental Health and Learning Disability	97,238	96,820	(418)
Delegated Co-Commissioning	103,270	104,181	911
Primary care	121,552	123,349	1,798
Other Programme	22,114	22,219	105
Sub Total Programme costs	**1,069,675**	**1,073,970**	**4,295**
Running costs	13,172	12,854	(318)
Sub Total CCG	**1,082,847**	**1,086,823**	**3,977**
Planned surplus/(deficit)	4,212	0	(4,212)
Total CCG after contributions to/from reserves	**1,087,059**	**1,086,823**	**(236)**
Historic surplus c fwd	23,441	0	(23,441)
Total CCG	**1,110,500**	**1,086,823**	**(23,677)**

OCCG has formal delegated responsibility from NHS England for GP Primary Care Commissioning and OCCG received an allocation of £97.2m in order to deliver this.

During the year OCCG spent £26.2m on COVID-19 related expenditure. The majority of this, £15.5m related to the Hospital Discharge Programme and £6.5m to Primary care responses to the pandemic including CALM clinics as well as funding bank holiday and weekend working in response to the pandemic. This COVID-19 spend was reimbursed in full.

During the year, OCCG continued joint commissioning and pooled budget arrangements with Oxfordshire County Council (OCC). There were two pooled budgets - the Better Care Fund (BCF) pool and the Adults with Care and Support Needs (ACSN) pool. The risk shares remained the same as for 2019/20. OCCG's contribution to the pooled budgets in 2020/21 was £174m while OCC contributed £198m.

OCC and OCCG have developed a new HESC (Health Education and Social Care) model for joint commissioning. The new governance structure went live from 1st April 2021 in the form of a new Joint Commissioning Executive (JCE). It is expected that a new Section 75 agreement will be enacted during the coming year.

It is the intention of both OCC and OCCG that the s75 agreement should be revised to reflect the increased ambition in HESC and the priorities of the JCE where these relate to the pooled budgets.

In line with national policy direction for the NHS, Oxfordshire CCG continues to work closely with Buckinghamshire and Berkshire West CCGs as part of the wider Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS)[7]. Organisations now work more closely together to make choices and decisions about how the Oxfordshire pound (£) is spent. Oxfordshire CCG has continued as the host organisation for the majority of funding from NHS England for the BOB ICS. £187m was received on behalf of the ICS during the year, including system top up, covid and growth funding for the second half of the year and was passed on to the other CCGs or direct to providers as agreed.

For the next financial year 2021/22, BOB ICS has been issued with a financial envelope by NHS England based on expenditure in Quarter 3 of 2020/21 and national inflation and growth assumptions. In May 2021, the ICS submitted its plans for the first half of the year. NHS England is yet to confirm the details of the financial regime for the second half of the year. Uncertainty in relation to the speed with which the NHS is able to recover from the pandemic and whether any further waves of infection occur, will influence how quickly a "new normal" financial and performance regime can be established.

[7] The NHS and local authorities across Buckinghamshire, Oxfordshire and Berkshire West (BOB) are working together to support delivery of the NHS Long Term Plan to deliver better health, better patient care and improved NHS efficiency.

Constitutional Targets

Below outlines the NHS constitutional targets OCCG has a duty to meet for 2020/21:

		Standard	Year-End Performance
Cancer	2 Week Waits	**93%**	**77.5%**
	2 WW Breast	**93%**	**30.2%**
	31D 1st Treatment	**96%**	**96.1%**
	31D Sub - Drug	**98%**	**99.5%**
	31D Sub -Radio	**94%**	**97.3%**
	31D Sub - Surgery	**94%**	**90.2%**
	62D Urgent Referral	**85%**	**79.6%**
	62D Screening	**90%**	**83.0%**
	62D Upgrade	**86%**	**68.2%**
RTT - Incomplete	RTT <18 wk waits	**92%**	**65.8%**
	RTT > 52 Week		**4075**
Diagnostics	< 6 weeks	**>1%**	**23.0%**
Mental Health	IAPT Access*	****5.87%**	**5.0%**
	IAPT Moving to Recovery	**50%**	**51.6%**
	IAPT 6 Week Wait	**75%**	**98.0%**
	IAPT 18 Week Wait	**95%**	**99.7%**
	Dementia Diagnosis Rate	**67%**	**61.3%**
C&YP Eating Disorders	Eating Disorders Urgent (1 week)	**95%**	**100.0%**
	Eating Disorders Routine (4 weeks)	**95%**	**57.7%**
	A&E		
A&E	< 4 Hour Waits OUH	**95%**	**88.2%**
Ambulance Response Times	Cat 1 - Mean	**7 mins**	**00:06:47**
	Cat 1 - 90th Percentile	**15 mins**	**00:13:36**
	Cat 2 - Mean	**18 mins**	**00:16:02**
	Cat 2 - 90th Percentile	**40 mins**	**00:30:29**
	Cat 3 - 90th Percentile	**120 mins**	**01:52:50**
	Cat 4 - 90th Percentile	**180 mins**	**02:21:46**

*Access = Performance (entering treatment)

**Standard = monthly target

The IAPT data is YTD until the end of Feb

Ambulance Response Times relates to Q4 as YTD is not available

1. The following collections have been paused nationally due to COVID-19
2. Mixed Sex Accommodation
3. Cancelled Operations
4. Nationally delayed transfers of care (DTOC) measure will no longer be reported nationally and will be replaced by a daily check of patients who

are medically ready for discharge and the proportions discharged on the defined pathways:

5. Pathway 0-home independent
6. Pathway 1-home with support
7. Pathway 2-to step down bed
8. Pathway 3-permanent care home placement

How does OCCG monitor performance?

The OCCG Board is responsible for discharging the duties of its constitution, which includes monitoring and scrutinising the performance of service providers. The Board receives an integrated performance report at the bi-monthly meetings in public.

Formal committees of the Board scrutinise in more detail how OCCG and health providers are delivering contracted services; these are the Finance Committee, the Audit Committee, Oxfordshire Primary Care Commissioning Committee, the Quality Committee and the OCCG Executive Committee (for more information about the committees and their purpose please see page 55). In addition to the monitoring requirements outlined above, the Accident & Emergency (A&E) Delivery Board also has a role to play in monitoring performance. Its members include the chief operating officers and board level representatives from NHS organisations in Oxfordshire and OCC. The group aims to develop and maintain resilience across the urgent care services and improve the flow of patients through A&E, admission, treatment and discharge.

How is OCCG monitored?

NHS England has a statutory duty to undertake annual assessment of CCGs. This is undertaken using the NHS Oversight Framework for 2019/20v which replaced the CCG Improvement and Assessment Framework (IAF). The new framework is intended as a focal point for joint work, support and dialogue between NHS England, NHS Improvement, CCGs, providers and integrated care systems.

Each CCG receives an overall assessment that places their performance in one of four categories: outstanding, good, requires improvement, or inadequate. OCCG received an overall rating of Good in the last published in assessment for 2019/20. Information on additional performance measures is available on https://www.nhs.uk/mynhs/index.html

Managing risk

Reducing risk across the health system is a priority for OCCG to ensure patients receive high standards of care. Risks are events or scenarios which can hamper OCCG's ability to achieve its objectives. These risks, divided into strategic and operational, are identified, assessed and managed by the organisation and reviewed at every OCCG Board meeting in public. They are continually reviewed at Board committee meetings including the Audit Committee, the Finance Committee, the Oxfordshire Primary Care Commissioning Committee, the Quality Committee and the OCCG Executive Committee. Board Committees and OCCG directors review all risks on a bi-monthly basis. The report on OCCG's principal, strategic and operational risks and mitigations as of 31 March 2021 can be found on OCCGs website here.

The year ahead

Through the year 2021/22 OCCG will remain the statutory organisation for commissioning health services in Oxfordshire. We will be focused on three core goals.

First, NHSE issued the Operating Plan Guidance 1[8] which contained a number of priorities for every system. This included recovery of elective care and non-COVID services as well as continuing to manage the vaccination programme and prepare for any future COVID waves. In Oxfordshire we are taking a system-wide approach to recovery, which places the health, social and economic wellbeing of Oxfordshire residents at its heart. Restart, Recover, Renew is an ambitious programme of work that considers the interdependencies between socio-economic factors, health outcomes, the economy, environmental matters and communities, and seeks to identify innovative joint solutions to shared challenges. We do not underestimate the challenge of dealing with the backlog of patients that have built up through the COVID pandemic.

Second, we need to prepare for organisational changes with the potential close down of the CCG and the safe transfer of CCG functions into an ICS body. In February 2021 the Department of Health and Social Care published a white paper[9] outlining a broad set of proposals for legislation which will be introduced to parliament later this year with a view that they will be enacted ahead of March 2022. The white paper proposes putting each ICS onto a statutory footing and the core CCG functions are subsumed into the ICS. While there is much that will be defined in guidance and legislation over the course of 2021 it is likely that a new commissioning organisation will be created across BOB that will launch in April 2022. We are already taking steps on governance arrangements for the three CCGs across BOB geography and to start developing 'committees in common.' We will be establishing a comprehensive transformation programme to manage this transition in the early part of 2021/22.

Thirdly, we need to ensure we can deliver the CCGs functions effectively and efficiently in 2021/22 whilst we also plan the transition of these functions to the new ICS body

We will only achieve these goals through our staff, partners and the volunteers who come together to help us deliver. COVID working is different and for many the work they are doing is different; the challenges of dealing with the backlogs is immense; and we are also all going through a period of organisation transition and dealing with the uncertainly that inevitably comes with change. We will be strengthening the support we give our staff throughout the year and working with them in co-design of the new organisation.

[8] Operating Plan Guidance (england.nhs.uk)
[9] Integration and innovation: working together to improve health and social care for all (HTML version) - GOV.UK (www.gov.uk)

Finally, I'd like to offer my thanks in advance to staff, partners, volunteers and the public for their help, challenge comments and scrutiny that I know will combine to deliver better health services for the residents of Oxfordshire over the coming year.

Dr James Kent
Accountable Officer
14 June 2020

Accountability Report

Corporate Governance Report

Members Report

OCCG's 67 member practices are grouped in three Network Areas: North, City and South.

North: The North Network Area is made up of 25 practices covering the registered population. The Network Area Clinical Director is Dr Sam Hart.

1. Alchester Medical Group
2. Bampton Surgery
3. Banbury Cross Health Centre
4. Bicester Health Centre
5. Bloxham Surgery
6. Broadshires Health Centre
7. Burford Surgery
8. Charlbury Surgery
9. Chipping Norton Health Centre
10. Cogges Surgery
11. Cropredy Surgery
12. Deddington Health Centre
13. Eynsham Medical Centre
14. Gosford Hill Medical Centre
15. Hightown Surgery
16. Islip Medical Practice
17. Montgomery House Surgery
18. Nuffield Health Centre
19. Sibford Surgery
20. The Key Medical Practice
21. Windrush Medical Practice, Witney

22. Windrush Surgery, Banbury
23. Woodlands Surgery
24. Woodstock Surgery
25. Wychwood Surgery

City: The City Network Area is made up of 20 practices covering the registered population. The Network Area Clinical Director is Dr Andy Valentine.

1. 19 Beaumont Street
2. 27 Beaumont Street
3. 28 Beaumont Street
4. Banbury Road Medical Centre
5. Bartlemas Surgery
6. Botley Medical Centre (and Kennington surgery)
7. Cowley Road Medical Practice
8. Donnington Medical Practice
9. Hedena Health
10. Hollow Way Medical Centre
11. Jericho Health Centre
12. King Edward Street Medical Practice
13. Luther Street Medical Centre
14. Manor Surgery
15. Observatory Medical Practice
16. St Bartholomew's Medical Centre
17. St Clement's Surgery
18. Summertown Health Centre
19. Temple Cowley Health Centre
20. The Leys Health Centre

South: The South Network Area is made up of 22 practices covering the registered population.

1. Abingdon Surgery
2. Berinsfield Health Centre
3. Chalgrove and Watlington Surgeries
4. Church Street Practice
5. Clifton Hampden Surgery
6. Didcot Health Centre
7. Goring and Woodcote
8. Long Furlong Surgery
9. Malthouse Surgery
10. Marcham Road Surgery
11. Mill Stream Surgery
12. Morland House Surgery
13. Nettlebed Surgery
14. Newbury Street Practice
15. Oak Tree Health Centre
16. Sonning Common Health Centre
17. The Bell Surgery
18. The Hart Surgery
19. The Rycote Practice
20. Wallingford Medical Practice
21. White Horse Surgery
22. Woodlands Medical Centre

Members of the Board

The names of the Clinical Chair and the Accountable Officer for Oxfordshire CCG are:

- Dr Kiren Collison, Clinical Chair, OCCG
- Dr James Kent, Accountable Officer, OCCG and Executive Lead for the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (ICS)

Along with Accountable Officer and Clinical Chair, the Board of OCCG comprises GP representatives, lay members, executive directors and a representative from Public Health. Adult Social Care and an external Medical Specialist. Individual profiles are available on OCCG's website here. The composition of the Board as at 31 March 2021 includes:

- Ansaf Azhar, Corporate Director of Public Health, Oxfordshire County Council
- Dr Ed Capo-Bianco, Urgent & Emergency Care Portfolio Clinical Director
- Stephen Chandler, Corporate Director Adults and Housing at Oxfordshire County Council
- Dr David Chapman, Mental Health, Learning Disability and Autism Portfolio Clinical Director
- Jo Cogswell, Director of Transformation
- Heidi Devenish, Practice Manager Representative
- Roger Dickinson, Lay Member Lead for Governance and Vice Chair
- Dr Sam Hart, North Network Clinical Director
- Dr Shelley Hayles, Planned Care Portfolio Clinical Director
- Diane Hedges, Chief Operating Officer
- Gareth Kenworthy, Director of Finance
- Catherine Mountford, Director of Governance
- Dr Guy Rooney, Medical Specialist Advisor
- Duncan Smith, Lay Member for Finance
- Dr Andy Valentine, City Network Clinical Director
- Sula Wiltshire, OCCG Board Nurse

Individual profiles are available on OCCG's website here

Profiles of OCCG Clinical Leads

Dr Ed Capo-Bianco

Urgent and Emergency Care Portfolio Clinical Director

My OCCG roles over the last 12 months include the Clinical Lead for Urgent Care, South Network Clinical Director, Clinical lead for Cardiovascular Disease, End of Life Care and Care Homes.

Within my urgent care role, I took the lead on developing a guidance document for GPs to manage feverish children during the pandemic. I pulled together a document containing emergency contact information for urgent care services in the hospital and community to share with GP colleagues.

I have been involved in system meetings and the development of the Home First, Discharge to Assess model of getting patients home sooner once they are medically fit and then assessing what social or therapeutic support they need in the short or long term.

I have also been closely involved in the roll-out of the 111 first programme in Oxfordshire, working with OUH, OH, SCAS and NHSE colleagues, helping to bring more practices on board with the scheme, ensuring that patients are directed to the most appropriate service for their needs. Further work from this has led to the development of speciality specific urgent care pathways and same day emergency care services.

As part of my cardiovascular work, we have continued to hold regular meetings with both cardiology and stroke services; the integrated cardiology service has continued to roll out to more localities and maintained its service throughout the pandemic.

Throughout the year we (OCCG planned care team, public health colleagues, Oxford AHSN and local clinical experts) have been working on a monitoring blood pressure at home scheme, developing a practice and patient information pack, which has been shared across the BOB ICS. We have been able to expand the offer based on the more recent NHSE initiative, where the initial focus had been on practices which cover the most deprived populations, although all other practices are now able to join.

My End of Life care and care home work is more recent, but already we are identifying some key priorities and workstreams to develop for End of Life care, working alongside OUH, Oxford Health, Sobell Hospice, Katherine House Hospice and Sue Ryder. The next stage of the care home work is to build on what has already been in place in Oxfordshire, ensuring the new Enhanced Health in Care Homes framework is adopted and that the excellent medical support to care homes is maintained and developed.

Boards and Committees

- Oxfordshire Clinical Commissioning Group Board

Dr David Chapman

Clinical lead for Mental Health, Learning Disabilities and Autism Portfolio Clinical Director

During this year I have been working with the OCCG managers to continue business as usual for patients with mental health (MH) issues. The MH teams have continued to see patients with urgent or crisis needs while routine patients have been managed effectively where possible with remote consultations. There have been surges in MH needs in secondary care especially when lockdowns have eased, although GPs have seen a continuous flow of people not referred with MH presentations.

A 24/7 MH helpline was set up initially using Oxford Health NHS FT (OH) staff and is now routed through 111 during this year. We have recognised that those with Severe Mental Illness (SMI) are a very vulnerable group during the pandemic and have encouraged GP practices to continue delivering Annual health Checks (AHC) over the year.

We have also focussed on delivering flu and COVID vaccinations to those with LD and SMI as well as supporting practices with our secondary care LD service and encouraging delivery of AHCs. We achieved 72% in the year 2020/21 thanks to great work from our GP practices.

During this time, I have been involved alongside our County Council colleagues with the recommissioning of the Dementia support service and the carers support service.

During Waves 1 and 2 of the pandemic I was involved in the Bronze cells for care homes and End of Life (EoL)as and was able to contribute to linking services and issuing medication across systems, together with simplifying anticipatory drugs. I was on a group developing easy pathways to admit those at EoL to community settings if needed. I also worked with colleagues in OH and General Practice to develop the system for multi -disciplinary teams using remote resources and overcoming GDPR issues. I also sat on the bereavement Silver cell across BOB to collate, develop and publicise bereavement services for patients and relatives.

I completed the work of collating and updating information on the Hospital at Home service in Oxfordshire and linking the OH service in with the other three services working in the community

I lead on eRS (electronic referrals) for OCCG. We have continued to roll out eRS for our MH providers over the year and will be completing this programme soon

Other business has continued including attending board meetings, being part of the new Joint Commissioning executive (between OCC and OCCG) and part of the local MH ICP. I have been involved in discussions about the development of the ICS at BOB level.

Boards and Committees

- Oxfordshire Clinical Commissioning Group Board

- Oxfordshire Clinical Commissioning Group Executive Committee
- Oxfordshire Clinical Commissioning Group Quality Committee
- Oxfordshire CCG and Oxfordshire County Council Joint Commission Executive

Dr Sam Hart

North Network Clinical Director

During an extraordinary year, my role at Oxfordshire CCG evolved from a smaller (North East Locality) to the role of clinical director of the larger North PCN Network, with effect from October 2020.

During the local pandemic response, I have been involved in a number of OCCG co-ordinated initiatives, including clinical input for the CALM service - the Oxfordshire Primary Care service, which diverted the most infectious confirmed or suspected COVID patients from practices to dedicated clinics and a visiting service.

I have been closely involved in the development of the Primary Care COVID Oximetry at Home service (PCCO@h), ensuring we can provide oversight by patients' own GPs wherever possible, and the co-ordination of this service with other key stakeholders (e.g. South Central Ambulance Service, Oxford Health NHS FT and Oxford University Hospitals NHS FT) to ensure patients get timely access to the most appropriate levels of care.

The PCCO@h project group continues to explore areas of development: via distribution of oximeters supported with educational material to more deprived groups in collaboration with the Academic Health Science Network; and expanding remote disease monitoring into other non-COVID chronic conditions via a new digital platform procured across BOB.

Boards and committees

- Oxfordshire Clinical Commissioning Group Board
- OCCG executive committee

Dr Shelley Hayles

Planned Care Portfolio Clinical Director

My clinical director role this year has been very different in planned care and cancer. Nothing was 'planned' about COVID. The planned care team has worked on establishing the information needed to maintain as much business as usual, by prioritising

certain pathways and straight to test, liaising with the Thames Valley Cancer Alliance to keep cancer referrals and services on track in those areas that have been most affected by the pandemic.

This has been linked to the Executive board and the Governing body transformation strategy and I have worked closely with my counterparts in Buckinghamshire and Berkshire West, especially where cancer is concerned, to ensure we are working to maximise our capacity.

My primary care role within the TVCA has been to advise on the clinical priorities and to liaise carefully with our providers around their activity at such a difficult time. As the RDC TVCA primary care lead I have also been heavily involved in continuing to establish this service, despite the waves of COVID, as it is designed to alleviate unnecessary use of our scarce resources and builds heavily on the success of the Oxford SCAN pathway.

The pandemic has led to innovative and novel ways of working and has also led to escalating changes in the way we practice, that might otherwise have taken decades. Some projects and innovative pathways have gone on hold while we have worked hard at getting people to come forward when they have worrying symptoms, supporting GPs in referrals, and negotiating pathways with the providers.

The OCCG planned care team are now looking forward to next year, when we can restart some new projects to streamline the patient pathway cross all service provision, in turn supporting the strategies of the ICS to improve capacity and quality of care.

Boards and Committees

- Oxfordshire Clinical Commissioning Group Board
- Oxfordshire Clinical Commissioning Group Executive Committee

Other Networks

- Thames Valley Cancer Alliance

Dr Paul Park

Interim Clinical Lead for Informatics

I have been in this role since September 2020 covering for my colleague Tom Nichols, who is on parental leave.

I have continued Tom's work to develop and check EMIS referral proformas and advising the Finance Team at OCCG on informatics and IT strategy, including advancing implementation of the Health Information Exchange (HIE) across Oxfordshire for population health.

Dr Meenu Paul

Assistant Clinical Director for Quality and Clinical Lead for Medicines Optimisation

It has been a pleasure to be in these two roles working and supporting my colleagues across the health and social care system in Oxfordshire.

As Assistant Clinical Director for Quality in Oxfordshire, my role has been working on quality issues in Primary Care and with Oxford Health NHS Foundation Trust.

The COVID pandemic has had an enormous impact in primary care for patients and clinical staff with the change to triage first appointments. I worked with the OCCG team to develop an identification system for patients who are at high risk of morbidity eg those who have not had a chronic disease review, patients who needed improvement in control of their chronic disease and ensuring patients from ethnic minority groups and those living in areas of deprivation were included. It was important to prioritise these patients for reviews to prevent deterioration of their health during the pandemic.

I am also the GP Lead for Infection control at OCCG and with my team we produced a series of guidelines for practices in relation to PPE and prevention of COVID transmission in practices. I have chaired meetings for the county wide influenza vaccination group. The vaccination rates for influenza have improved in 2020/21 in Oxfordshire - the result of very good collaboration across the primary, secondary, community, pharmacy and social care setting.

I chair the Oxfordshire Area Prescribing Committee where decisions are made in collaboration with partners across the health care setting. These are related to clinical prescribing guidelines, shared care protocols and evaluation of new medicines for the Oxfordshire Prescribing Formulary. The committee is fortunate to have patient representation which has helped to inform our decisions.

I look forward to the next 12 months which will see a lot more collaborative working with Buckinghamshire Oxfordshire and Berkshire West to improve outcomes for patients and their experience of health and social care.

Boards and Committees

- Oxfordshire Clinical Commissioning Group Board
- Oxfordshire Clinical Commissioning Group Executive Committee
- Oxfordshire Area Prescribing Committee

Dr Andrew Valentine

City Network Clinical Director & Clinical Director of Quality

Over the last 12 months I have worked in OCCG roles as Clinical Director of Quality, Clinical Lead for CAMHS, Deputy Locality Clinical Director for Oxford City (until Oct 2020) and City Network Clinical Director (from October 2020). From the onset of the pandemic, I worked on the COVID End of Life Care Workstream and contributed to developing the Ethical Framework for the Oxfordshire Healthcare System during the COVID-19 Pandemic. I have continued to work with the OUH on Quality issues, reviewing serious incidents, and developing safer cancer referral pathways within the Trust.

In my role as CAMHS Clinical Lead I had responsibility for ensuring commissioned pathways remained safe and effective, whilst also needing to change to become COVID-aware.

I have chaired Member Practice Commissioning Forum Meetings in my role as Network Clinical Director and contributed to OCCG board and clinical executive meetings as we transition towards working as an ICS. I work on the Primary Care COVID Oximetry at Home workstream, and have led a project to consider how access and knowledge regarding pulse oximetry could be more equitable across populations.

Boards and Committees

- Quality Commission

Other clinical leads working with OCCG include:

- Dr Mary Akinola (Individual Funding Request Clinical Lead)
- Dr Lucy Jenkins (Area Prescribing Committee Oxfordshire Clinical Lead)
- Dr Amar Latif (Long Term Conditions Clinical Lead)
- Dr Merial Raine (Safeguarding Clinical Lead)
- Dr Gwyneth Rogers (Safeguarding Clinical Lead)

- Dr Sue Ruddock (Area Prescribing Committee Oxfordshire Clinical Lead)
- Dr Nick Thomas (Individual Funding Request Clinical Lead)

Statement of Disclosure to Auditors

Each individual who is a member of the Board at 31 March 2021 confirms:

- so far as the Board member is aware, that there is no relevant audit information of which the clinical commissioning group's external auditor is unaware and;
- that the Board member has taken all the steps that they ought to have taken as a member in order to make themselves aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information.

Please see the Annual Governance Statement on page 53 for information about the committees of the Board including membership and attendance.

The Board member Register of Interests is available on the CGGs website here.

Personal Data Related Incidents

There have been no personal data related incidents formally reported to the information commissioner's office.

Modern Slavery Act

OCCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Statement of Accountable Officer's 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 appointed Dr James Kent to be Accountable Officer of NHS Oxfordshire Clinical Commissioning Group.

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 a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts 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 income and expenditure, Statement of Financial Position and cash flows for the financial year.

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

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;

- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

As the 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 Ernst & Young LLP auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Dr James Kent
Accountable Officer
14 June 2021

Annual Governance Statement

NHS Oxfordshire Clinical Commissioning Group is a body corporate established by NHS England on 1 April 2018 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 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 of 1 April 2021, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

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.

In accordance with Section 15.4 of the CCG Constitution, the CCG has the following statutory committees:

- The Audit Committee
- The Remuneration Committee
- The Primary Care Commissioning Committee

It has also established:

- Executive Committee
- Finance Committee
- Quality & Performance Committee

The terms of reference for each of these committees have been ratified by the Governing Body, and the minutes are publicly available along with those of the Governing Body meeting papers (except for the Remuneration Committee). Each committee submits an annual report to the Governing Body giving assurance they are carrying out their duties.

During the whole of 2020/21 the NHS has been responding the COVID-19 pandemic. This has included operating at Level 4 (national control) or Level 3 (regional control) for most of the year. This required some amendment to the way the CCG operated including the following:

- Implementation of COVID-19 Specific and temporary framework of meetings; this was presented to the Governing Body at its meeting on 9 June and is available here
- Governing Body and Primary Care Commissioning Committees were held virtually as meetings in public with attendees able to submit questions

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (ICS)

The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (ICS) operates as a partnership to support each place and organisation within the system for the delivery of services, constitutional standards and requirements of the NHS Long Term Plan. This also includes groups for system leaders to regularly meet, along with financial and delivery oversight. The role of the ICS is to

- Improve population health and healthcare
- Tackle unequal outcomes and access
- Enhance productivity and value for money
- Help the NHS to support broader social and economic development

Governing Body

The Governing Body includes six GPs (the South Network Clinical Director post is currently vacant) as representatives from member practices, all of which are also members of the Executive Committee. Regular meetings are held with member practices in the three network areas. Member practices can influence strategy and key decisions such as expressing confidence (or otherwise) in the Governing Body or Executive Committee.

The responsibilities of the CCG are detailed within section 9 of the Constitution (functions and general duties), and the roles and responsibilities of members of the Governing Body are in section 14. The standing orders, the prime financial policies and the scheme of reservation and delegation are referenced within sections 11, 12, 14 and 15, as well as separate documents on the CCG website here.

Through adoption of the Constitution the Practice Members have agreed that the Governing Body will be responsible for:

- Assurance including audit and remuneration
- Assuring the decision-making arrangements
- Oversight of arrangements for dealing with conflict of interest
- Leading the setting of vision and strategy
- Quality
- Financial stewardship of public funds
- Promoting patient and public engagement
- Approving commissioning plans on behalf of OCCG
- Monitoring performance against plan
- Providing assurance on strategic risks

The Practice Members are represented on the Governing Body through six member GPs (currently one vacancy) who are appointed in line with Standing Orders.

The Governing Body agenda for the CCG in 2020/2021 has included reporting and decisions on:

- Budget setting and arrangements for annual report and accounts
- Standing items on quality, finance, contracting and performance
- Review of Quality, Innovation, Productivity and Prevention (QIPP) plans
- Review of strategic risks through the Governing Body Risk Report;

- Ratification of policies and procedures as required.
- NHS Long Term Plan and 5 year strategy
- Annual Reports on safeguarding and committee work
- Communications and engagement activity
- Developing Primary Care Networks
- Developing the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System
- Emergency Preparedness. Resilience and Response (EPRR) and winter preparedness
- Response to and recovery from COVID-19, including governance accountability and compliance with statutory duties

The Governing Body also reviewed its own governance arrangements and effectiveness, as well as the Terms of Reference of its committees. The registers of conflicts of interest and gifts and hospitality were both reviewed.

Governing Body Committees

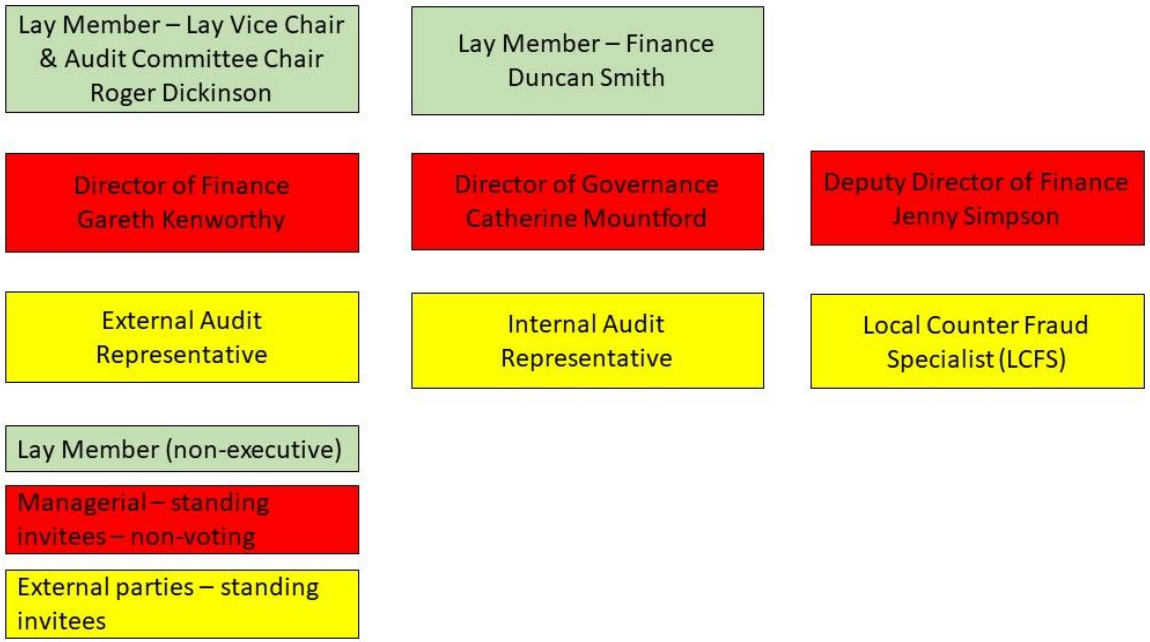
All committees outlined provide assurance to the Governing Body through presentation of their minutes and an annual report. The Committees may also undertake self- assessments of their effectiveness.

Audit Committee

Reviews critically the CCG's financial reporting and internal control principles; ensures that all the CCG activities are managed in accordance with legislation and regulations governing the NHS; ensures adequate assurance is in place over the management of significant risks; and ensures that appropriate relationships with both internal and external auditors are maintained.

The Committee met six times in 2020/21. This included extraordinary Audit Committee meetings in April and May 2020 to approve the submission of the draft and final Statutory Accounts and Annual Reports.

Audit Committee Members as at 31 March 2021



The Committee receives regular reports to provide it with assurance from:

- the Director of Finance and deputies on finances and performance, losses and special payments and single tender waivers
- Internal Audit and External Audit – including reports on the outcome of reviews together with recommendations on any necessary actions
- the Local Counter Fraud Specialist (LCFS)
- the Director of Finance and Governance Manager in respect of the Strategic and Operational risk registers
- The Director of Governance in respect of corporate governance including conflicts of interest exceptions, gifts, hospitality,

sponsorship, joint working agreements

- The Senior Information Risk Owner (SIRO) in respect of data security and protection arrangements

The Accountable (Chief) Officer and other executive directors attend meetings as requested. Representatives of internal audit, external audit and local counter fraud service attend each meeting. A meeting in private session with the Lay Members is also held at least once per annum. The agenda of the Audit Committee is governed by its annual business cycle.

Remuneration Committee

This Committee reviews the framework for the Remuneration, Allowances and Terms of Service for employees of the CCG and for people who provide services to the CCG. It makes recommendations to ensure effective oversight of the performance of the CCG's Chair, Accountable (Chief) Officer, Director of Finance, and other senior posts, and for scrutiny of any redundancy payments.

The committee met five times in 2020/21. Three of the five meetings were 'in common' with the Remuneration Committees of NHS Buckinghamshire Clinical Commissioning Group and NHS Berkshire West Clinical Commissioning Group.

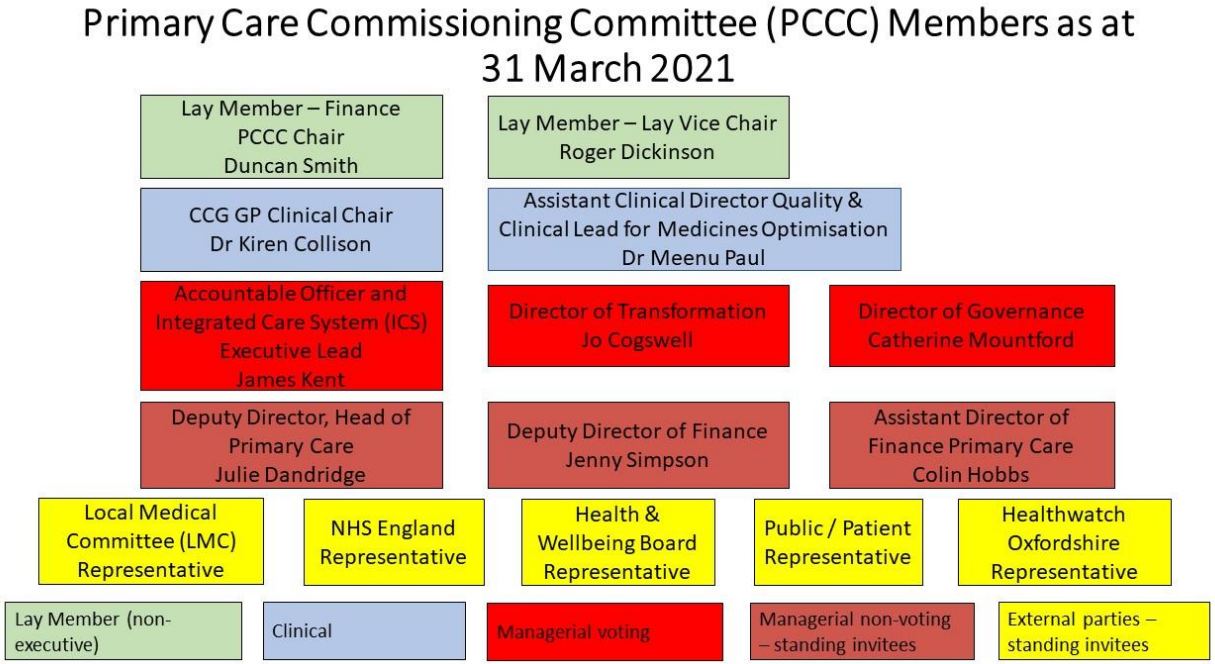
The overall purpose of this committee is to assure the Governing Body that the duty to act effectively, efficiently and economically has been met, and that use of resources for remuneration does not exceed any amount specified.

Primary Care Commissioning Committee

The Committee is established in accordance with the statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Oxfordshire under delegated authority from NHS England.

Meetings are held four times a year and in public. Health and Wellbeing Board representatives and NHS England are also invited to attend in accordance with the Delegation Agreement.

The CCG chair is a voting member. The Committee met three times in 2020/2021 as one meeting was stood down during response to the COVID-19 pandemic.



The Committee undertakes the following activities:

- Review and monitor GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, taking contractual action such as issuing breach/remedial notices, and removing a contract) and enhanced services ("Local Commissioned

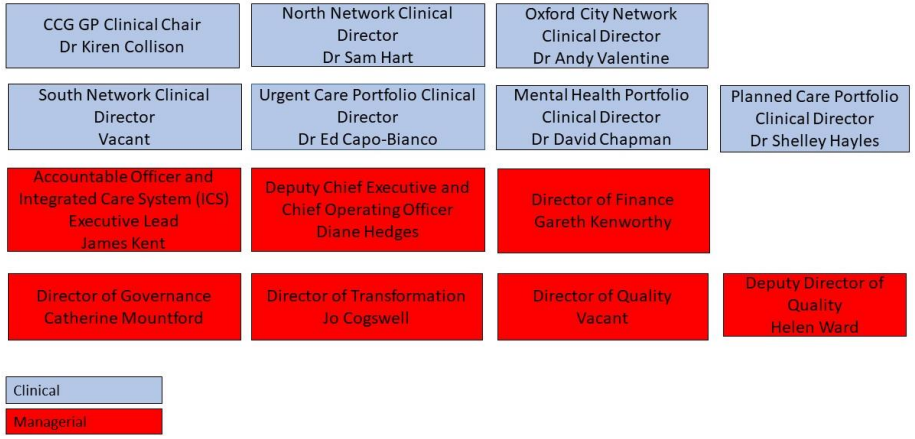
Services" and "Directed Enhanced Services")

- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF)
- Decision making on whether to establish new GP practices in an area and to approve practice mergers and making decisions on 'discretionary' payments
- To plan, including needs assessment, primary care services in Oxfordshire and undertakes and delivers a primary care estates strategy across the Oxfordshire area
- To undertake reviews and manage the budget for commissioning of primary care services in Oxfordshire and to co-ordinate a common approach to the commissioning of primary care services generally
- To assist and support NHS England in discharging its duty under section13E of the NHS Act 2006 (as amended by the Health and Social Care Act2012) so far as relating to securing continuous improvement in the quality of primary medical services

Executive Committee

The Executive Committee is responsible for the overall management and delivery of the operational plan and its associated work programmes and has the responsibility for day-to-day management of the CCG and certain functions as delegated by the Governing Body. Some of the delivery of these functions is delegated to committees of the Executive Committee. The Committee met 11 times in 2020/21, although a number of these meetings were shortened to essential business due to the COVID-19 pandemic.

Executive Committee Members as at 31 March 2021



Certain matters are considered at most meetings as part of a standing agenda including the Finance, Performance and Quality Reports alongside corporate risks.

In addition to the standing items, the Executive Committee also considered the following items which include discussion, reporting and decision making under delegated authority:

- Commenting on proposed changes to the commissioning of some primary care services (extended access, early visiting service and City Social prescribing)
- Mental Health services
- Developing Primary Care Networks
- Developing the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System
- MSK, community gynecology, musculoskeletal, audiology and termination of pregnancy procurements
- Review of terms of reference and corporate objectives
- Response to and recovery from COVID-19 – including hospital discharge, command and control arrangements and local outbreak control plan
- Emergency Preparedness Resilience and Response (EPRR), winter preparedness, flu outbreak planning and CCG business continuity plans
- Joint Strategic Needs Assessment and the Director of Public Health Annual Report

While the Executive Committee does not meet in public, its minutes are available to the public within the Governing Body papers.

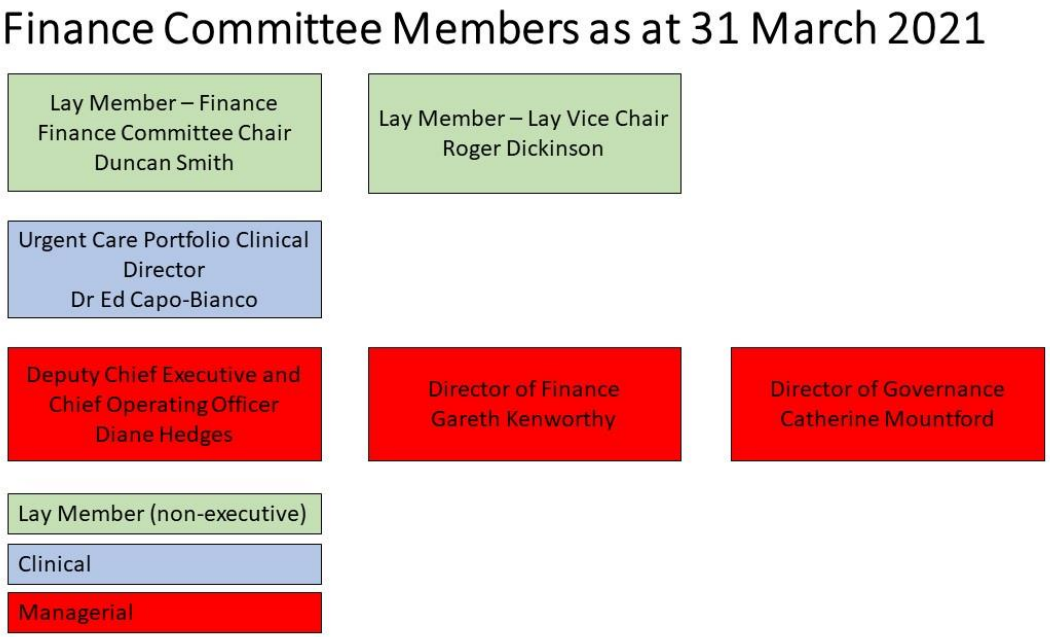
The CCG also works across the Health and Social Care system on Urgent Care through the A&E Delivery Board. This includes representatives of key providers and commissioners of Urgent Care Services. The Board escalates to the Executive as and when required.

Finance Committee

The Finance Committee scrutinises the financial plans and performance in relation to key national targets and in support of the delivery of the outcomes included in the NHS Long Term Plan. It also takes relevant decisions as required under delegated authority, such as business cases.

The Committee reviews reports, identifying key issues and risks and gives opinion and assurance to Governing Body on the stewardship of CCG financial resources and their going concern status. Additionally, the Governing Body may request that the Finance Committee reviews specific aspects of financial performance where they require additional scrutiny and assurance.

The Committee met eight times in 2020/21.



The work of the Committee also includes the following activities:

- Monitor use of financial resources and to ensure that value for money can be demonstrated and that the best possible value is secured for the Oxfordshire pound
- Scrutiny of Quality, Innovation, Productivity and Prevention (QIPP) and Cost Improvement Programmes (CIPs)
- Evaluate, scrutinise and quality assure the financial validity of the investment, disinvestment and business case framework.
- Maintain an overview of the value for money provided by the CCG's expenditure, contracts and support arrangements (for example, the contract provided by NHS South, Central and West Commissioning Support Unit)
- Approves the release of finance from allocated reserves to support investments and to make recommendations to the

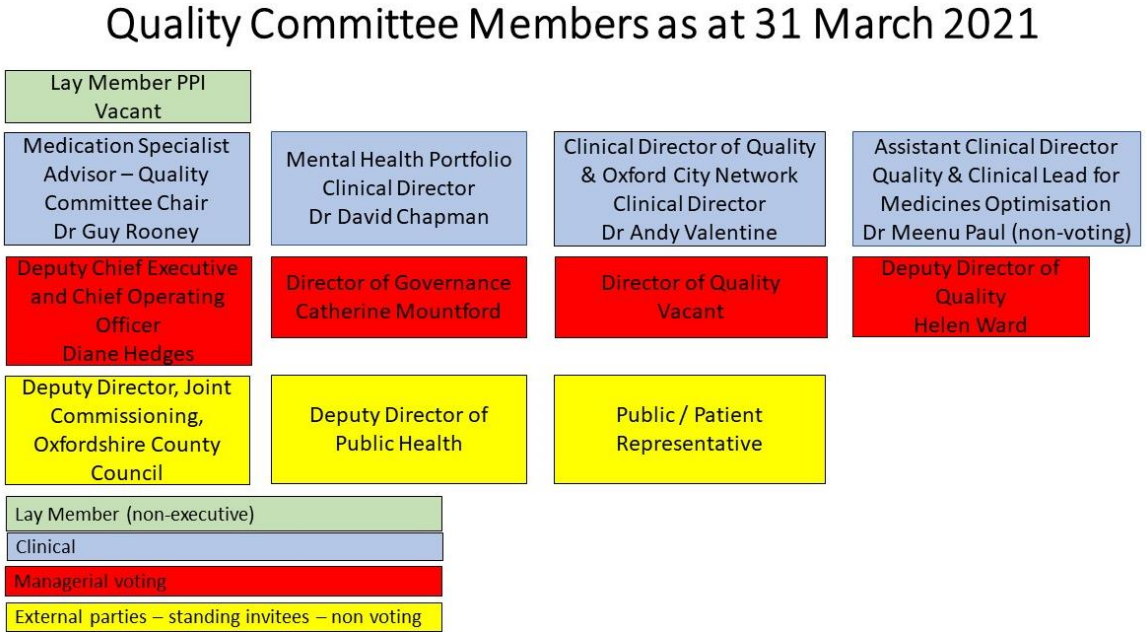
Governing Body as appropriate.

- Advise the Governing Body on relevant reports by NHS England, regulators and other national bodies, and, where appropriate, management's response to these.
- Monitors and provides a scrutiny function across other areas of financial activity.

Quality and Performance Committee

Reviews and assures provider performance; has oversight of the quality and safety of commissioned services considering safety, effectiveness and patient experience; ensures that the patient voice is heard; reviews reports on Serious Incidents and Never Events; ensures that there are processes in place to safeguard adults and children; considers national quality inspection reports; monitors arrangements relating to equality and diversity; reviews the corporate risk register; and receive chairs reports from various subcommittees for oversight and assurance.

It promotes a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness, outcomes and patient experience. This includes a responsibility to promote research and the use of research and monitor reports made to the National Reporting and Learning System. The Committee met three times in 2020/21.



The work of the Committee also includes the following activities:

- Assure the Governing Body in respect of constitutional standards e.g. Stroke services, cancer waiting times and A&E performance etc., alongside safeguarding, infection control, incident management, complaints, workforce data, staff surveys, reporting of quality accounts, or any other area of quality
- Receive assurance on performance and quality and clinical risks, and compliance with National Institute for Health and Care Excellence (NICE) Quality Standards
- Receive assurance on Quality Impact Assessments (QIAs), to assess any impact on quality and performance, in order to provide challenge where necessary
- Ensure that there is a continuing structured process for leadership, accountability and working arrangements for quality and performance within the CCG
- Approval and ratification of policies relating to quality and patient safety

Compliance with the 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 relevant to the clinical commissioning group and best practice. This Corporate Governance Report is intended to demonstrate the clinical commissioning group compliance with the principles set out in the Code.

For the financial year ended 31 March 2021 and up to the signing of the statement, we complied with the provisions set out in the Code and applied the principles of the Code.

Discharge of Statutory Functions

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, the accountable officer, 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 the clinical commissioning group’s statutory duties.

Risk management arrangements and effectiveness

The Audit Committee reviews the full Strategic Risk Register at every meeting; the Quality Committee reviews and

discusses risks relating to quality and performance; the Finance Committee reviews and discusses financial risks; the Primary Care Commissioning Committee reviews and discusses Primary Care risks and the CCG Executive Committee reviews and discusses the strategic risks bi-monthly.

The Governance Team co-ordinates production of risk registers offers advice and training (when required) and works with Executive Directors via the Directors Risk Review meeting. This meeting is chaired by the Director of Governance and attended by all Executive Directors. The remit of the meeting is to identify new risk areas ensuring they are managed effectively and to review the quality of recording of current risks including an up-to-date description of the risk rating and providing an overview that all risks are managed appropriately. The Governance Team also maintains the risk cycle ensuring that timely reminders are sent to risk managers for each risk cycle as per Board and sub-committee meetings.

Proposed new risks are presented as drafts to the Executive at the Directors Risk Review meeting for approval ahead of inclusion on the risk register. Strategic risks are only closed with approval from the Executive and the Board. Operational risks are closed with the approval of a Directorate Head of Service.

Executive Directors are responsible for using risk management as a tool to identify and analyse risks in relation to their area of responsibility and to ensure that suitable and sufficient action is taken to mitigate risks. Each Executive Director is responsible for ensuring the Risk Register is updated and provide assurance to the Committees and the Board.

OCCG staff are responsible for maintaining risk awareness, identify and reporting risks as appropriate to their line manager, ensuring they are familiar with the Risk Management Policy and undertaking risk management training as appropriate to their role.

OCCG has no appetite for fraud/financial risk and zero tolerance for regulatory breaches. The CCG supports well managed risk taking and will ensure that the skill, ability and knowledge are there to support innovation and maximise opportunities to improve services. The Audit Committee and the Directors Risk Review meeting will review the appetite statement on an annual basis and propose any changes to the Board.

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.

Annual audit of conflicts of interest management

The CCG recognises the potential for interests of members to conflict with the business of the CCG; consequently, the CCG has embedded within its governance, a number of policies, protocols and processes to ensure that potential conflicts are recognised and managed, and that decisions are made only by those who do not have a vested interest.

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 CCGs internal auditors carried out this audit for 2020/21 and made three low priority and two medium action recommendations to ensure staff are compliant with statutory and mandatory training requirements, conflicts of interests and mitigating actions are clearly recorded for meetings and registers and these were all addressed. The training compliance as at 31 March 2021 was 89.1%. Outstanding training is being followed up.

Data Quality

The sourcing of data and management of provider data quality is achieved via contracts. The data contract management processes are well established in Oxfordshire, and we continue to capitalise on strong relationships between NHS South Central and West Commissioning Support Unit and information governance teams within provider organisations to drive continuous improvement.

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.

The CCG is due to submit a Data Security and Protection Toolkit for 2020/21 by the end of June 2021. The date for submission was extended by NHS England due to the pressure on organisations caused by the COVID-19 pandemic.

The CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. An information governance management framework and processes and procedures are in place and aligned to the information governance toolkit. All staff undertake annual information governance training, and a staff information governance handbook is promoted to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. In 2020/21, there were no incidents which required reporting to the information Commissioner's Office.

Information Governance is reported to the Audit Committee as a standing agenda item in each meeting and is reviewed regularly through the CCG management meetings.

Business Critical Models

The CCG is aware of the Macpherson Report on government business critical models and quality assurance mechanisms, and of its findings. The CCG does not operate any business-critical models as defined in the report.

Third party assurances

Where the CCG relies on third party providers, it gains assurance through service level agreement and contract specifications; regular review meetings with providers on multiple levels; the use of performance data and external regulatory inspection reports; and monitoring and review by appropriate programme boards and committees. Third party assurances is reported to the Audit Committee and informs this governance statement and external audit conclusion.

Control Issues

As identified in the Month 9 Governance Statement return NHS Constitutional requirements are not being met by providers.

Activity is below normal levels as a result of the cancellation and suspension of routine work due to COVID-19. The Integrated Care System task and finish groups have developed and actioned plans including sharing activity across the three acute Trusts in Buckinghamshire, Oxfordshire and Berkshire West (BOB). Urgent referrals and existing patients are being seen as normal utilizing technology to enable non-face-to-face appointments. Specialties with high 52 week wait numbers have agreed trajectories to contain the potential growth.

Cancer services are being prioritized and a recovery trajectory for each of the tumour sites developed as well as a Rapid Diagnostic Service through the Thames Valley Cancer Agency for Lung and Colorectal in the first instance. A recovery action plan is also in place for two week wait breast performance around outpatient and radiologist capacity. Pathway recovery work is taking place to look at auditing the pathway changes made during COVID and the impact it has had.

Alternative options and flow management process were scoped internally and across the system to address in-patient mental health delays. GP communications continued to encourage uptake of learning disability and serious mental illness health checks and a deep-dive and oversight of recovery plans was undertaken by NHS England. The Children and Adolescent Mental Health Service offered a digital delivery for most new referrals and the City and North Mental Health Support Team provided online support to schools, parent and young people with pilots meeting key milestones.

The A&E performance at month 9 of 86.9% was below the 95% 4 hour standard, although an improvement on the 2019/20 average of 83.1%. Type 1 performance also saw an improvement from 80.1% to 84.8%. There has been a significant reduction in the number of A&E attendances.

During the first wave of the pandemic OCCG amended the way meetings were operated, both in terms of whether held and what would be considered. A framework was produced, and mechanisms put in place on the principle that meetings only took place if decisions were required at that point in time in line with the Scheme of Delegation and Reservation with assurance and performance updates taken by exception. This framework was reintroduced with meetings cancelled or shortened during January and February 2021.

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

The CCG has well-established systems and processes for managing its resources effectively, efficiently, and economically.

The Governing Body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place, and delegates responsibilities to the Audit Committee, the Quality Committee and the Finance Committee. The Chief Finance Officer has delegated responsibility to determine arrangements to ensure a sound system of financial control. An audit programme is followed to ensure that resources are used economically, efficiently, and effectively.

The Audit Committee met regularly throughout the 2020/21 financial year to review and monitor the CCG's financial reporting and internal control principles; to ensure that the CCG activities were managed in accordance with legislation and regulations governing the NHS; and to ensure that appropriate relationships were maintained with internal and external auditors.

The Finance Committee met throughout the year to monitor contract and financial performance, savings plans and overall use of resources; to approve business cases and release of finance from allocated reserves; and to monitor and provide a scrutiny function to ensure the delivery of projects within the CCG's care programme boards.

The CCG has processes in place to secure economy, efficiency and effectiveness through its procurement, contract negotiation and contract management processes. There are regular performance review meetings on the following contracts: Royal Berkshire NHS Foundation Trust (hospital services), Berkshire Healthcare NHS Foundation Trust (community and mental health services), and South-Central Ambulance Services. Effectiveness is monitored specifically through the quality processes and Quality Committee.

The Chief Finance Officer has met regularly with the CCG's finance team and held monthly meetings with the CSU's finance leads to review month-end reporting. Regular meetings are also held with the local authorities' finance leads.

The CCG informs its control framework by the work over the year of the Internal and External Audit functions. As part of their annual audit, the CCG's external auditors are required to satisfy themselves that the CCG has made proper arrangements for securing economy, efficiency, and effectiveness in the use of its resources. Their audit work is made available to and reviewed by the Audit Committee and Governing Body.

The CCG has not yet received the annual rating from NHSE&I.

Delegation of functions

The CCG's Scheme of Reservation and Delegation outlines the control mechanisms in place for delegation of functions and is found in the Constitution.

The Governing Body receives reports from each of its Committees detailing the delivery of work, and associated risks, within their specific remit. Additionally, the Governing Body maintains a high-level overview of the organisation's business and identifies and assesses risks and issues straddling Committees. These risks are owned and overseen at Governing Body level and scrutinised at each meeting to ensure appropriate management and reporting.

Internal Audit is used to provide an in-depth examination of any areas of concern.

Counter fraud arrangements

The CCG is committed to reducing the risk from fraud and corruption and discharges its counter fraud responsibilities locally through its appointed Local Counter Fraud Specialist (LCFS) who acts as the "first line of defence" against fraud, bribery, and corruption, working closely with the CCG and NHSCFA. The Chief Finance Officer is the Executive Lead for Counter Fraud. The CCG has a Counter Fraud and Corruption Policy and Response Plan in place, and this was reviewed in January 2021.

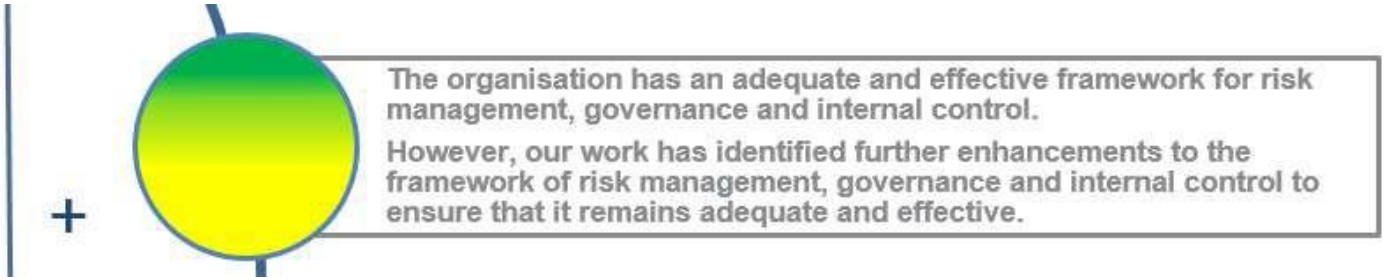
Fraud awareness material, including fraud alerts and information on bribery, is regularly circulated to CCG staff. Fraud referrals are investigated by the LCFS and the progress and results of investigations are reported to the Chief Finance Officer and the Audit Committee. Audit Committee receives a report each meeting on an aspect of counter-fraud work. There is a proactive risk-based work plan aligned to the NHSCFA Standards for Commissioners to maintain and improve compliance and performance against each of the standards is assessed on an annual basis.

The CCG also participates in the National Fraud Initiative Exercise now run by the Cabinet Office which is a mandatory exercise that matched electronic data within and between public and private sector bodies to prevent and detect fraud. It has been run every two years since 1996.

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:

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's annual governance statement.



For the 12 months ended 31 March 2021, our Head of Internal Audit opinion for Oxfordshire Clinical Commissioning Group, is as follows:

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

Audit Area	**Assurance Level**
Financial Governance Arrangements	Substantial
Conflicts of Interest	Reasonable
Delegated Commissioning	Reasonable

Cyber Security	Advisory
Governance – Alignment of Arrangements (Draft)	Advisory
ICS Transformation Funding	Substantial
Financial Governance – Part 2	Reasonable

There are no issues from our work to date that we believe the CCG needs to consider as significant control issues.

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 strategic risk register itself provides me with evidence of the effectiveness of controls that manage risks to the clinical commissioning group achieving its principle objectives have been reviewed.

I have been guided on the effectiveness of controls through the oversight of the Board and its committees and this has also informed my review. If necessary, a plan to addresses weaknesses, for example responses to audit recommendations and ensure continuous improvement of the system, will be put in place.

Conclusion

No significant internal control issues have been identified.

Dr James Kent
Accountable Officer
14 June 2021

Remuneration and Staff Report

Remuneration Committee

Each clinical commissioning group has a Remuneration Committee; the role of the committee is to advise on appropriate remuneration levels and terms of service for the Executive Team and Clinical Leads. Details of membership and terms of reference of the Remuneration Committee are available on page 59.

Policy on the remuneration of senior managers

Senior managers' remuneration is set through a process that is based on a consistent framework and independent decision-making based on accurate assessments of the weight of roles and individuals' performance in them. This ensures a fair and transparent process via bodies that are independent of the senior managers whose pay is being set. No individual is involved in deciding his or her own remuneration.

Executive senior managers are ordinarily on permanent NHS contracts. The length of contract, notice period and compensation for early termination are set out in the Agenda for Change, NHS terms and conditions of service handbook.

All GPs on the OCCG Board have employment contracts and are paid via payroll.

Policy on the remuneration of very senior managers

All very senior manager remuneration (VSM) is determined by OCCG's Remuneration Committee based on available national guidance, benchmarking data against other CCGs and with due regard for national pay negotiations/awards for NHS staff on national terms and conditions. The Remuneration Committee is also cognisant of public sector pay restraint and its responsibility to ensure that executive pay remains publicly justifiable. The Remuneration Committee acknowledges and commits to complying with the requirement to seek pre-approval from NHS England for salaries in excess of £142,500.

Senior Manager Remuneration (including salary and pension entitlements) 2020/21

Name	Title	Oxfordshire CCG Salary & Fees (Bands of £5000) £000	Taxable benefit (rounded to nearest £100) £00	Annual Performance Related Bonuses (Bands of £5000) £000	Long Term Performance Related Bonuses (Bands of £5000) £000	All Pension Related Benefits (Bands of £2500) £000	TOTAL Oxfordshire CCG (Bands of £5000) £000
Board members							
Ed Capo-Bianco	South East Locality Clinical Director	65-70	0	0	0	7.5-10	70-75
David Chapman	Oxford City Locality Clinical Director	65-70	0	0	0	0	65-70
Joanne Cogswell	Director of Transformation	115-120	0	0	0	27.5-30	140-145
Kiren Collison	Clinical Chair	25-30	0	0	0	10-12.5	35-40
Heidi Devenish	Practice Manager Representative	0-5	0	0	0	20-22.5	20-25
Sam Hart	Network Clinical Director North	35-40	0	0	0	0	35-40
Shelley Hayles	North Locality Clinical Director	70-75	0	0	0	0	70-75
Diane Hedges	Chief Operating Officer and Deputy Chief Executive	120-125	0	0	0	30-32.5	150-155
James Kent	Accountable Officer	65-70	0	0	0	35-37.5	100-105
Gareth Kenworthy	Director of Finance	120-125	1	0	0	27.5-30	150-155
Amar Latif	Interim Governing Body Member	35-40	0	0	0	7.5-10	35-40
Catherine Mountford	Director of Governance	110-115	0	0	0	17.5-20.0	130-135
Guy Rooney	Medical Specialist Advisor	10-15	0	0	0	0	10-15
Andy Valentine	City Network Clinical Director	75-80	0	0	0	7.5-10	75-80
Ursula Wiltshire	Board Nurse	80-85	0	0	0	0	80-85
Fiona Wise	Acting Accountable Officer and ICS Lead	20-25	0	0	0	0	20-25
Non Executive Board							
Roger Dickinson	Independent Lay Member, Lead for Governance and Vice Chair	20-25	0	0	0	0	20-25
Duncan Smith	Independent Lay Member, Lead for Finance	15-20	0	0	0	0	15-20
Louise Wallace	Independent Lay Member, Lead for Patient Participation and Involvement	10-15	0	0	0	0	10-15

Notes:

- James Kent is Accountable Officer for the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) and is recharged from Buckinghamshire CCG. The remuneration for 2020/21 shown above is a proportion of his total salary and is based on “fair shares” (average registered population relative to the two other CCGs in the ICS) which equates to 40.15% for Oxfordshire. James Kent is contractually entitled to a performance bonus for 2020/21 which has not been included in these figures as a result of not being settled in the year.
- Fiona Wise was Acting Accountable Officer and ICS Lead for three months for Oxfordshire and Buckinghamshire CCG and was then replaced by James Kent. She was seconded from Buckinghamshire CCG so that the remuneration for 2020-21 shown above is a proportion of her total salary. She was not a member of the pension scheme during this time.
- The costs for Gareth Kenworthy were recharged in part to the ICS in 2019/20. In 2020/21 his costs are wholly within Oxfordshire CCG.
- Ursula Wiltshire was an Executive Director until 31 January 2021 and from 1 February has been an independent member of the Governing Body covering the role of Board Nurse.
- Louise Wallace left OCCG on 31 December 2020

All appointments to the Governing Bodies, other than those described as "officers" are substantive employees of the CCGs. Those who are officers have fixed term contracts with their specific arrangements described in the table below:

Governing Body Officers	Role on Governing Body	Date of Contract	Unexpired Term	Notice Period	Provision for compensation for early termination
Dr Kiren Collison	Clinical Chair	01/12/2017	34 weeks	12 weeks	Nil
Roger Dickinson (1)	Lay Member, Audit Committee Chair & Vice Chair	01/04/2013	12 weeks	12 weeks	Nil
Duncan Smith (2)	Lay Member and Finance & Primary Care Commissioning Committee Chair	01/04/2013	56 weeks	12 weeks	Nil
Dr Ed Capo-Bianco (3)	Urgent Care Portfolio Clinical Director	15/05/2017	52 weeks	12 weeks	Nil
Dr David Chapman (3)	Mental Health Portfolio Clinical Director	12/07/2014	52 weeks	12 weeks	Nil
Dr Sam Hart (3)	North Network Clinical Director	01/09/2020	52 weeks	12 weeks	Nil
Dr Shelley Hayles (3)	Planned Care Portfolio Clinical Director	16/04/2018	52 weeks	12 weeks	Nil
Dr Andy Valentine (3)	Oxford City Network Clinical Director	01/09/2020	52 weeks	12 weeks	Nil
Heidi Devenish	Practice Manager Representative	01/05/2018	52 weeks	12 weeks	Nil
Guy Rooney (4)	Medical Specialist Advisor	01/06/2016	104 weeks	12 weeks	Nil
Sula Wiltshire	Registered Nurse on the Board	01/02/2021	17 weeks	12 weeks	Nil

1) Extended on 07/04/2021 to 30/06/2021
2) Extended on 01/05/2018 to 30/04/2022
3) Extended on 01/10/2020 to 31/03/2022
4) Extended on 01/04/2020 to 31.03.2023

Senior Manager Remuneration (including salary and pension entitlements) 2019/20

Name	Title	Oxfordshire CCG Salary & Fees (Bands of £5000) £000	Taxable benefit (rounded to nearest £100) £00	Annual Performance Related Bonuses (Bands of £5000) £000	Long Term Performance Related Bonuses (Bands of £5000) £000	All Pension Related Benefits (Bands of £2500) £000	TOTAL Oxfordshire CCG (Bands of £5000) £000
Board members	0						
Ed Capo-Bianco	South East Locality Clinical Director	60-65	0	0	0	15 - 17.5	75 - 80
Miles Carter	West Locality Clinical Director	60-65	0	0	0	0 - 2.5	60 - 65
David Chapman	Oxford City Locality Clinical Director	50-55	0	0	0	0 - 2.5	50 - 55
Kiren Collison	Clinical Chair	90-95	0	0	0	17 - 19.5	105 - 110
Jonathan Crawshaw	Locality Clinical Director	35-40	0	0	0	17 - 19.5	50 - 55
Heidi Devenish	Practice Manager Representative	0-5	0	0	0	2.5 - 5	5 - 10
Diane Hedges	Chief Operating Officer and Deputy Chief Executive	115-120	0	0	0	120 - 122.5	235 - 240
Gareth Kenworthy - see no	Director of Finance	115-120	1	0	0	60 - 62.5	175 - 180
Catherine Mountford	Director of Governance	105-110	1	0	0	2.5 - 5	105 -110
Louise Patten	Chief Executive	75-80	0	0	0	32.5 - 35	110 - 115
Guy Rooney	Medical Specialist Advisor	5-10	0	0	0	0 - 2.5	5 - 10
Ursula Wiltshire	Director of Quality and Innovation	80-85	1	0	0	0 - 2.5	80 - 85
Non Executive Board							
Roger Dickinson	Independent Lay Member, Lead for Governance and Vice Chair	15-20	3	0	0	0 - 2.5	20 - 25
Duncan Smith	Independent Lay Member, Lead for Finance	15-20	0	0	0	0 - 2.5	15 - 20
Louise Wallace	Independent Lay Member, Lead for Patient Participation and Involvement	15-20	1	0	0	0 - 2.5	15 - 20

Notes:

- Louise Patten was seconded from Buckinghamshire CCG so that the remuneration for 2019/20 shown above was a proportion of her total salary.
- The CCG receives a contribution towards the costs of Gareth Kenworthy for his role within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS).

Pension Benefits as at 31 March 2021

Name	Title	Notes	Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at pension age at 31 March 2021 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1st April 2020 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2021 £'000	Employer's contribution to stakeholder pension £'000
Board members										
Ed Capo-Bianco	South East Locality Clinical Director		0-2.5	0-2.5	10-15	15-20	126	11	140	0
David Chapman	Oxford City Locality Clinical Director		0	0	0	0	0	0	0	0
Joanne Cogswell	Director of Transformation		0-2.5	0-2.5	5-10	0	82	27	111	0
Kiren Collison	Clinical Chair		0-2.5	0-2.5	15-20	25-30	229	14	248	0
Heidi Devenish	Practice Manager Representative		0-2.5	0-2.5	0-5	0	39	12	52	0
Sam Hart	Network Clinical Director North		0-2.5	0-2.5	10-15	0	167	0	149	0
Shelley Hayles	North Locality Clinical Director		0	0-2.5	0	0	0	0	0	0
Diane Hedges	Chief Operating Officer and Deputy Chief Executive		0-2.5	0-2.5	35-40	65-70	684	51	747	0
James Kent	Accountable Officer		2.5-5	0-2.5	0-5	0-5	25	36	67	0
Gareth Kenworthy	Director of Finance		0-2.5	0-2.5	35-40	75-80	613	41	664	0
Amar Latif	Interim Governing Body Member		0-2.5	0-2.5	10-15	15-20	144	5	155	0
Catherine Mountford	Director of Governance		0-2.5	2.5-5	40-45	125-130	943	83	1,042	0
Andy Valentine	City Network Clinical Director		0-2.5	0-2.5	10-15	20-25	174	11	188	0
Ursula Wiltshire	Board Nurse		0	0	0	0	0	0	0	0

Notes:

- James Kent joined in May 2020 as Accountable Officer and ICS Lead.
- Lay members and the Specialist Medical Advisor do not receive pensionable remuneration.
- The CCG has been unable to obtain the total accrued pension and lump sum at pension age as at 31 March 2021, and the cash equivalent transfer value as at 31 March 2021 and 31 March 2020, from the NHS Pensions Agency in respect of David Chapman, Oxford City Locality Clinical Director.
- No disclosures are required for those already in receipt of their pension.
- The calculations above do not take account of the McCloud judgement (This was a legal case which concluded there had been age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the eldest members who retained a Final Salary design). The outcome of the case means that all eligible members are members of their legacy scheme for the period between 1 April 2015 and 31 March 2022, known as the remedy period. Eligible members retiring after implementation will get a choice of whether to take legacy or reformed scheme benefits for the remedy period when their pension benefits become payable. This is known as the deferred choice underpin. The financial implications of this have not yet been worked through nationally or at an organisational level.

Cash Equivalent Transfer Value

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 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. The CETV calculated as at 31 March 2020 and 31 March 2021 may be calculated using different methodologies and to highlight that this change may have impacted the real increase in CETV figure.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Pension Benefits as at 31 March 2020

Name	Title	Notes	Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at pension age at 31 March 2020 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1st April 2019 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2020 £'000	Employer's contribution to stakeholder pension £'000
Board members										
Ed Capo-Bianco	South East Locality Clinical Director		0-2.5	0-2.5	10-15	15-20	112	11	126	0
Miles Carter	West Locality Clinical Director		0-2.5	0-2.5	0-5	0 - 5	0	0	0	0
David Chapman	Oxford City Locality Clinical Director		0-2.5	0-2.5	0-5	0 - 5	791	0	0	0
Kiren Collison	Clinical Chair		0-2.5	0-2.5	15-20	25-30	207	18	229	0
Jonathan Crawshaw	Locality Clinical Director		0-2.5	0-2.5	15-20	15-20	151	8	169	0
Joanne Cogswell	Director of Transformation		5-7.5	0-2.5	5-10	0 - 5	0	76	82	0
Heidi Devenish	Practice Manager Representative		0-2.5	0-2.5	0-5	0 - 5	35	3	39	0
Shelley Hayles	North Locality Clinical Director		0-2.5	0-2.5	0-5	0 - 5	0	0	0	0
Diane Hedges	Chief Operating Officer and Deputy Chief Exective		5-7.5	10-12.5	30-35	65-70	622	48	684	0
Gareth Kenworthy - see note below	Director of Finance		2.5-5	2.5-5	35-40	75-80	536	64	613	0
Catherine Mountford	Director of Governance		0-2.5	0-2.5	40-45	120-125	882	40	943	0
Will O'Gorman	Locality Clinical Director		2.5-5	7.5-10	15-20	40-45	201	74	280	0
Louise Patten	Chief Executive		2.5-5	0 - 2.5	35-40	45-50	601	57	672	0
Guy Rooney	Medical Specialist Advisor		0 - 2.5	0 - 2.5	0 - 5	0 - 5	0	0	0	0
Ursula Wiltshire	Director of Quality and Innovation		0-2.5	0 - 2.5	0 - 5	0 - 5	0	0	0	0

Notes:

- Louise Patten - seconded from Buckinghamshire Clinical Commissioning Group.
- Lay members and the Specialist Medical Advisor do not receive pensionable remuneration.
- The calculations above do not take account of the recent McCloud ruling (This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the eldest members who retained a Final Salary design). We believe this is appropriate given there is still considerable uncertainty on how the affected benefits within the new NHS 2015 scheme would be adjusted in future once the wider impact of the court ruling has been considered.

Workforce Remuneration: Pay Multiple

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

The banded remuneration of the highest paid director/member of the OCCG Board in the financial year 2020/21 was £155k - 160k (2019/20 was £155k to £160k) on an annualised basis. This was 2.96 times (2019/20 3.1 times) the median remuneration of the workforce, which was £53,168 (2019/20 £50,836).

In 2020/21, 1 employee (2019/20 1 employee) received remuneration in excess of the highest paid director/member of the OCCG Board. Remuneration ranged from £22,000 to £182,000 (2019/20 £15,000 to £182,000).

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.

Staff Report

Staff sickness absence

For information about sickness absence data for 2020/21 please go here.

Sickness absence is managed in a supportive and effective manner by OCCG managers, with professional advice and targeted support from human resources (HR), occupational health, employee assistance programme and staff support services which are appropriate and responsive to the needs of our workforce. OCCG's approach to managing sickness absence is governed by a clear HR policy and this is further supported by the provision of HR advice and training sessions for all line managers on the effective management of sickness absence.

Managers ensure that the culture of sickness reporting is embedded within their teams and sickness absence is actively monitored and formally reported to OCCG on a quarterly basis as part of the workforce reporting process.

OCCG proactively promotes the health and wellbeing of staff in line with its Health and Wellbeing Policy. The policy is implemented by an active staff led Health and Wellbeing Group who organise events throughout the year with a large number of staff participating. Events have included fund raising activities, annual sporting challenge and events aimed to support employees wellbeing. During January 2020 a new initiative, the 'Daily Mile' was introduced which sees a group of staff walking a

mile every day at lunchtime. The walk has a team leader and staff benefit from time out of the office to support their physical, emotional, social and mental health.

Staff numbers and gender analysis

OCCG has a workforce comprised of employees from a wide variety of professional groups. At the end of 2020/21 OCCG employed 114 staff (headcount), of which 86 were women and 28 men. As of 31 March 2021, the Board of OCCG was made up of 7 women and 11 men. Below is a breakdown of gender analysis. The membership body of OCCG is made up of all 67 (as of 31 March 2021) GP practices within Oxfordshire; a breakdown of membership by gender is not available.

Below outlines the gender breakdown of staff:

	Female Headcount	Male Headcount	Total Headcount
CEO and Board	7	11	18
Very Senior Managers including GPs	13	12	25
All other Employees	71	14	85
Total Employees	86	28	114

The below table shows the number of people (headcount) employed by OCCG and others employed by other organisations or temporary staff who are working for OCCG:

	2020/21 Permanently employed Number	Other Numbers	20/21 Total Number
Total	88	26	114
Of the above: Number of whole time equivalent	80.75	18.71	99.46
(WTE) people engaged on capital projects	0	0	0

Trade union official facility time

OCCG has one trade union representative who worked 18 hours (1.5 hours per month) during 2020/21 at a cost of £282.60.

Number of employees who were relevant union officials during the relevant period	**Full-time equivalent employee number**
1	0.6WTE

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

Percentage of pay bill spent on facility time	
Provide the total cost of facility time	£1,210
Provide the total pay bill	22033
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	5.5%
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	100%

Expenditure on consultancy

Expenditure on consultancy was £29k in 2020/21 (£171k in 2019/20) as per Note 5 to the Accounts page 120. Expenditure appeared low in 2020/21 due to a prior year accrual of £83k which offset the expenditure in year.

Off Payroll Engagements

Under Treasury guidance PES (2013) 09, all public sector organisations are required to disclose information about high paid off payroll appointments. As at 31 March 2021 there were no off payroll engagements for more than £245 per day that lasted longer than six months. The CCG did not make any new off payroll engagements, or any that reached six months in duration, which cost more than £245 per day, between 1 April 2020 and 31 March 2021.

For any off-payroll engagements of Board members and senior officials with significant financial responsibility, between 01 April 2020 and 31 March 2021 – see below:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	0
Total no. of individuals on payroll and off-payroll who have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements. (2)	7

There were no non-contractual severance payments made following judicial mediation, and no payments relating to non-contractual payments in lieu of notice.

Exit Packages 2020/21

There were no exit packages in the year 2020/21 and consequently no associated payments.

Analysis of Other Agreed Departures

There were no departures made in the year 2020/21 or the previous year 2019/20 in respect of voluntary redundancy, ill health retirements, mutually agreed resignations, early retirements in the efficiency of the service, payments in lieu of notice, exit payments following employment tribunals or court orders or non-contractual payments requiring HMT approval.

Redundancy and other departure costs would be paid in accordance with the provisions of OCCG's Compulsory Redundancy Scheme in line with Agenda for Change standard entitlements where applicable.

Any exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

OCCG has not agreed any early retirements. If it had, the additional costs would be met by OCCG and not by the NHS Pension Scheme, and would be included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

No non-contractual payments (£0) were made to individuals where the payment value was more than 12 months of their annual salary.

The Remuneration Report would include the disclosure of exit payments payable to individuals named in that Report. There were none during 2020/21.

Health & wellbeing of staff

OCCG proactively promotes the health and wellbeing of staff in line with its Health and Wellbeing Policy. The policy is implemented by an active staff led Health and Wellbeing Group. The group has been working hard to support colleagues with various initiatives since the start of the pandemic:

- The OCCG Health and Wellbeing Team channel was set up in MS Teams for staff to share lockdown-friendly entertainment and cooking recipe suggestions, as well as tips and ideas for maintaining fitness routines.
- Weekly Wellbeing Wednesday sessions began in June 2020 and are open to all OCCG staff and those across the BOB ICS; these sessions provide mindfulness activities and stretching exercises for staff to follow.
- The fortnightly OCCG All Staff Coffee mornings have been running since August 2020 and have provided staff with an informal environment to meet and share interests and suggestions for ways to keep entertained and healthy during the pandemic. A special event was hosted in February for staff to share their experiences and ways of coping with the challenges of living in the lockdown.
- In addition, there have been seasonal quizzes and activities such as a pumpkin carving competition where staff were invited to submit photos of their Halloween creations.

The activities have been based on MS Teams and been well received and attended by staff across a range of teams and directorates.

The Employee Assistant Programme (EAP) is a free service for staff to anonymously access impartial advice and counselling services. The service supports staff with a range of things including managing stress, coping with bereavement, relationship breakdown, debt advice or a challenge or issue which could benefit from being talked through.

A weekly staff update commenced at the beginning of the pandemic and has continued throughout the year; it includes lots of work-related information and also signposts to resources for mental and physical wellbeing. The weekly update has been well received by staff across the organisation.

Staff Policies

OCCG recognise and value the importance of maintaining positive working relationships with its staff and their representatives. The Staff Partnership Forum (SPF) is its joint management and staff forum for staff engagement and consultation. In December

2020 the SPF joined together with staff partnership forums from Buckinghamshire and Berkshire West CCGs to form a single BOB wide forum; a key focus of the BOB SPF was wellbeing and inclusion of staff.

OCCG have actively and successfully worked in partnership on a number of issues affecting staff including the development and review of human resources policies. We are also aligning policies with those of Buckinghamshire and Berkshire West CCGs to support the BOB ICS. Policies are ratified by OCCG's Executive prior to publication.

The BOB SPF is representative of the workforce and OCCG recognises all of the trade unions outlined in the national NHS Terms and Conditions of Service Handbook who have members employed within the organisation.

OCCG has a Health and Wellbeing Policy and an active, staff led, Health and Wellbeing Group which is responsible for the implementation of this policy. Events are held throughout the year with a large number of staff participating. Events have included fund raising activities, annual sporting challenge and events aimed to support employees wellbeing.

OCCG with the BOB SPF have developed a range of methods to communicate and encourage meaningful, two-way dialogue with staff include:

- Weekly BOB ICS Accountable Officer Staff Briefings
- Monthly staff briefings led by the CCG's Executive Team which includes a question and answer session
- CCG and BOB ICS Staff surveys to drive improvement in staff experience
- Staff development / training sessions with opportunities across the BOB ICS

The results of the staff surveys have been assessed by the BOB SPF, themes identified and an action plan developed by staff to address different aspects of the feedback. This has resulted in the development of a more agile working approach and focus on OCCG values. Managers hold regular one-to-one meetings with staff and use the values-based appraisal system ensuring all staff work towards clearly defined personal objectives and standards of behaviour. These are supported with learning, training and development opportunities detailed in individual Personal Development Plans.

Disability information

OCCG has developed an integrated approach to delivering workforce equality so it does not have a separate policy for disabled employees or for any other protected characteristics. Equalities issues are incorporated in policies covering all aspects of the employee lifecycle ranging from recruitment to performance. OCCG's aim is to provide an environment in which all staff are engaged, supported and developed throughout their employment and to operate in ways which do not discriminate our potential or current employees by virtue of any of the protected characteristics specified in the Equality Act 2010. OCCG is also

committed to supporting employees to maximise their performance including making any reasonable adjustments that may be required on a case-by-case basis.

OCCG is committed to implementing the Workforce Race Equality Standards (WRES) and will work with those organisations it commissions services from and partners to ensure employees from black and ethnic minority backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The 2020 WRES return is available on the CCGs website here.

Equality and Diversity

For information of the Workforce Race Equality Standard and how we give 'due regard' to eliminating discrimination please see the annual submission which is available here. Information is also available on www.nhs.uk/mynhs

Health and safety

OCCG recognises that the maintenance of a safe work place and safe working environment is critical to our continued success and accordingly, we view our responsibilities for health, safety and welfare with the upmost importance. However the past year the majority of staff have been working from home. During this time, considerable effort has gone into supporting staff as they continue to work from home. This included all staff undertaking risk assessments of their 'at home' working environment and purchasing equipment (for example office chairs and monitor) to accommodate individual staff need.

Health and Safety training forms part of the suite of statutory and mandatory training which is undertaken by all employees.

Whistleblowing

Oxfordshire CCG has a whistleblowing policy that is communicated to all staff and available on the CCG staff intranet.

Auditable elements

Please note that the elements of this remuneration and staff report that have been subject to audit are the tables of salaries and allowances of senior managers and related narrative notes on page 74 and 76, pension benefits of senior managers and related narrative on pages 77 to 79, the pay multiples and related narrative notes on page 80 and exit packages and any other agreed departures on page 84.

Dr James Kent
Accountable Officer
14 June 2020

Parliamentary Accountability and Audit Report

Oxfordshire Clinical Commissioning Group is not required to produce a Parliamentary Accountability and Audit Report but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report. For 2020/21 there were no remote contingent liabilities, gifts, fees or charges. Below outlines the total number of OCCG's losses and special payments cases, and their total value:

	Total Number of Cases	**Total Value of Cases**	Total Number of Cases	Total Value of Cases
	2020-21	**2020-21**	2019-20	2019-20
	Number	**£'000**	Number	£'000
Fruitless payments	2	1	0	0
Cash losses	1	0	0	0
Total	**3**	**1**	0	0

Dr James Kent
Accountable Officer
14 June 2020

Independent Auditor's Report to the members of the Governing Body of Oxfordshire Clinical Commissioning Group

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS OXFORDSHIRE CLINICAL COMMISSIONING GROUP

Opinion

We have audited the financial statements of NHS Oxfordshire Clinical Commissioning Group for the year ended 31 March 2021 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 20. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2020/21 HM Treasury's Financial Reporting Manual (the 2020/21 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2020/21 and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England (the Accounts Direction).

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Oxfordshire Clinical Commissioning Group as at 31 March 2021 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the Health and Social Care Act 2012 and the Accounts Directions issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the clinical commissioning group ("the CCG") in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.
We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

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

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for a period of at least 12 months from when the financial statements are authorised for issue.
Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the CCG's ability to continue as a going concern.

Other information

The other information comprises the information included in the annual report set out on pages 3-103, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

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

We have nothing to report in this regard.

Opinion on other matters prescribed by the Health and Social Care Act 2012

Basis for qualification on the Remuneration Report
The Remuneration Report set out on pages 73 to 88 of the Annual Report and Accounts 2020/21, does not disclose the Total Accrued Pension at Pension Age, Lump Sum at Pension Age or the Cash Equivalent Transfer Value at Pension Age for the Oxford City Locality Clinical Director because the information was not provided by the NHS Pensions Agency.

Qualified opinion on the Remuneration Report
Except for the reasons set out in the basis for qualification on the Remuneration Report, in our opinion the part of the Remuneration Report subject to audit has been prepared properly in accordance with requirements of the Department of Health and Social Care Group Accounting Manual.

Opinion on the Staff Report
In our opinion the part of the Staff Report subject to audit has been prepared properly in accordance with requirements of the Department of Health and Social Care Group Accounting Manual.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued by the NHS Commissioning Board; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in these respects.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's Responsibilities in respect of the Accounts, set out on pages 51-52, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial

statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income. In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or has no realistic alternative but to do so.

As explained in the Annual Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- *We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant are the Health and Social Care Act 2012 and other legislation governing NHS CCGs, as well as relevant employment laws of the United Kingdom. In addition, the CCG has to comply with laws and regulations in the areas of anti-bribery and corruption and data protection.*

- *We understood how NHS Oxfordshire Clinical Commissioning Group is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance.*

- *We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur by planning and executing a journal testing strategy, testing the appropriateness of relevant entries and adjustments. We have considered whether judgements and estimates made in relation financial performance, especially in months 12 and 13, are indicative of potential bias, and considered whether the CCG is engaging in any transactions outside the usual course of business.*

- *Based on this understanding we designed our audit procedures to identify noncompliance with such laws and regulations. Our procedures involved enquiry of management and those charged with governance, reading and reviewing relevant meeting minutes of those charged with governance and the Governing Body and understanding the internal controls in place to mitigate risks related to fraud and non-compliance with laws and regulations.*

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in April 2021, as to whether the CCG had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Report on Other Legal and Regulatory Requirements

Regularity opinion

We are responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (the "Code of Audit Practice").

We are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

In our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Certificate

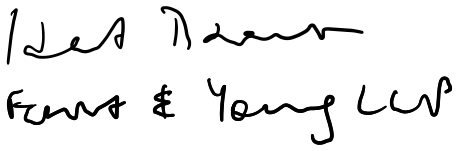
Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed our procedures on the CCG's value for money arrangements for the year ended 31 March 2021. We are satisfied that this work does not have a material effect on the financial statements. We will report the outcome of our work on the CCG's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

Until we have completed these procedures, we are unable to certify that we have completed the audit of the accounts in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice issued by the National Audit Office.

Use of our report

This report is made solely to the members of the Governing Body of NHS Oxfordshire Clinical Commissioning Group in accordance with Part 5 of the Local Audit and Accountability Act 2014 and for no other purpose Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the members as a body, for our audit work, for this report, or for the opinions we have formed.



Janet Dawson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
London
18 June 2021

Glossary of Terms

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS): The NHS and local authorities across Buckinghamshire, Oxfordshire and Berkshire West are working together to support delivery of NHS England's Five Year Forward View to deliver better health, better patient care and improved NHS efficiency.

Care Quality Commission: monitors, inspects and regulates hospitals, care homes, GP surgeries, dental practices and other care services to make sure they meet fundamental standards of quality and safety

Clinical Chair: medical doctor at the head of Oxfordshire Clinical Commissioning Group.

Delayed Transfer of Care (DTOC): occurs when a patient is ready to leave a hospital or similar care provider but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice.

GP Federation: a group of GP practices which come together to provide a greater range of services to patients in their local area eg OxFed Health and Wellbeing Board (HWB Board): key leaders from the health and social care services and Healthwatch work together to improve the health and wellbeing of their local population and reduce health inequalities

Healthwatch: UK consumer watchdog for patients which aims to improve health and social care

Joint Strategic Needs Assessment for Oxfordshire: provides information about the county's population and the factors affecting health, wellbeing, and social care needs.

Local Authorities: the elected bodies responsible for the most strategic local government services in the county.

Local Health Resilience Partnership: a group for local health organisations (including private and voluntary sector where appropriate) which looks at readiness and planning for major health emergencies

Local Medical Committee: a statutory body for local GPs which looks after the interests of family doctors

Locality Plans: intended to build resilient, sustainable primary care for the future based on local need. The plans are intended to support the vision for health services where patients will receive more care closer to home and be supported out of hospital as much as possible.

Medicines Optimisation Team: helps health professionals and patients make the right treatment and medicines choices by promoting cost effective and evidence based clinical practice and effective risk management

Mental Health Partnership: The Mental Health Partnership comprises Oxford Health Foundation Trust, Oxfordshire Mind, Restore, Response, Connection Floating Support and Elmore Community Services

National Institute for Clinical Excellence: provides national guidance and advice to improve health and social care. It aims to help medical practitioners deliver the best possible care; to give people the most effective treatments based on the latest evidence; to provide value for money; to reduce inequalities and variation

NHS Long Term Plan: The NHS Long Term Plan, published in January 2019, is a 10 year plan for the NHS to improve the quality of patient care and health outcomes. Its ambitions include measures to prevent 150,000 heart attacks, strokes and dementia cases, and better access to mental health services for adults and children.

Oxford Health Foundation Trust (OHFT): provides physical, mental health and social care for people of all ages across Oxfordshire, Buckinghamshire, Swindon, Wiltshire, Bath and North East Somerset. Its services are delivered at community bases, hospitals, clinics and people's homes.

Oxford University Hospitals NHS Foundation Trust (OUHFT): is one of the largest teaching hospitals in England. It is made up of four hospitals - the John Radcliffe Hospital, the Churchill Hospital and the Nuffield Orthopaedic Centre, all in Oxford, and the Horton General Hospital in Banbury. It provides a wide range of clinical services, specialist services (including cardiac, cancer, musculoskeletal and neurological rehabilitation), medical education, training and research.

Oxfordshire Joint Health and Wellbeing Strategy: The story of how the NHS, councils and Healthwatch work together to improve the health and wellbeing of people in Oxfordshire. The strategy has been developed with input from the people of Oxfordshire.

Oxfordshire Joint Health Overview Scrutiny Committee: looks at the work of the NHS clinical commissioning groups, healthcare trusts, and the NHS England Local Area Team. The committee acts as a 'critical friend' by suggesting ways that health related services might be improved.

Patient Participation Groups (PPG): Patient representatives from a GP practice who advise and inform the practice on what matters most to patients and to help identify solutions to problems as a ‘critical friend’

Primary Care: most people’s first point of contact with health services, for example, GPs, dentists, pharmacists or optometrists

Primary Care Networks: Primary care networks bring general practices together to work at scale. This helps to recruit and retain staff; manage financial and estates pressures; provide a wider range of services to patients and to more easily integrate with the wider health and care system. All GP practices are expected to come together in geographical networks covering populations of approximately 30– 50,000 patients by June 2019.

Referral to Treatment Times: The period of time from referral by a GP or other medical practitioner to hospital for treatment in the NHS South Central Ambulance NHS Foundation Trust (SCAS): SCAS provides and accident and emergency service to respond to 999 calls; the NHS 11 service for when medical help is needed fast but not a 999 emergency and a non-urgent patient transport service. It covers the counties of Berkshire, Buckinghamshire, Hampshire and Oxfordshire

Social prescribing: This process enables GPs, nurses and other primary care professionals to refer people to a range of local, non- clinical services.

Appendix 1: Table of Attendance for Board and Committee Meetings

(Membership in line with Constitution dated 14 January 2016)

OCCG Board (Governing Body)

Name	09/06/2020	30/07/2020	24/09/2020	26/11/2020	16/03/2021
Azhar, Ansaf		Apols	Apols	Apols	✓
Capo-Bianco, Ed (v)	✓	✓	Apols	✓	✓
Chandler, Stephen	✓	Apols	✓	Apols	✓
Chapman, David (v)	✓	✓	✓	✓	✓
Cogswell, Jo	✓	✓	✓	✓	✓
Collison, Kiren (v)	✓	✓	✓	✓	✓
Devenish, Heidi	✓	✓	✓	✓	✓
Dickinson, Roger (v)	✓	✓	✓	✓	✓
Hart, Sam (v)	✓	✓	Apols	✓	✓
Hayles, Shelley (v)	✓	✓	✓	✓	✓
Hedges, Diane	✓	✓	✓	✓	✓
Kenworthy, Gareth (v)	✓	Apols	✓	✓	✓
Kent, James (v)	Apols	✓	Apols	✓	✓
Latif, Amar (v)	✓	✓	✓	N/A	N/A
Mountford, Catherine	✓	✓	✓	✓	✓
Rooney, Guy (v)	✓	Apols	✓	Apols	✓
Simpson, Jenny (v)	N/A	✓	N/A	N/A	N/A
Smith, Duncan (v)	✓	✓	✓	✓	✓
Wallace, Louise (v)	✓	✓	✓	✓	N/A
Ward, Helen	N/A	N/A	✓	N/A	N/A
Wiltshire, Sula (v)	✓	✓	Apols	✓	✓

Audit Committee

Name	21/04/2020	27/05/2020	18/06/2020	15/10/2020	23/02/2021
Dickinson, Roger	✓	✓	✓	✓	✓
Kenworthy, Gareth	✓	✓	✓	✓	✓
Mountford, Catherine	✓	Apols	✓	✓	✓
Smith, Duncan	✓	✓	✓	✓	✓

OCCG Executive

Name	16/04/20	28/04/20	26/05/20	23/06/20	28/07/20	25/08/20	22/09/20	03/11/20	24/11/20	22/12/20	23/03/21
Capo-Bianco, Ed	✓	✓	✓	✓	✓	Apols	Apols	✓	✓	✓	✓
Chapman, David	✓	✓	✓	Apols	✓	✓	✓	✓	✓	✓	✓
Cogswell, Jo	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apols	✓
Collison, Kiren	✓	✓	Apols	✓	✓	Apols	✓	Apols	✓	Apols	✓
Hart, Sam	Apols	✓	Apols	✓	✓	✓	✓	✓	✓	✓	Apols
Hayles, Shelley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hedges, Diane	✓	✓	✓	✓	✓	✓	Apols	✓	✓	✓	Apols
Kenworthy, Gareth	✓	✓	✓	✓	Apols	✓	✓	✓	✓	✓	✓
Kent, James	N/A	N/A	Apols	Apols	Apols	Apols	Apols	✓	✓	Apols	✓
Latif, Amar	N/A	✓	✓	✓	✓	Apols	✓	N/A	N/A	N/A	N/A
Mountford, Catherine	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Simpson, Jenny	N/A	N/A	N/A	N/A	✓	N/A	N/A	N/A	N/A	Apols	N/A
Valentine, Andy	N/A	N/A	N/A	Apols	N/A	N/A	✓	✓	✓	✓	✓
Ward, Helen	N/A	✓	N/A	N/A	N/A	N/A	✓	N/A	N/A	N/A	✓
Wiltshire, Sula	✓	Apols	✓	✓	✓	✓	Apols	✓	✓	✓	N/A
Wise, Fiona	✓	✓	Apols	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Finance Committee

Name	**28/05/2020**	**23/07/2020**	**15/09/2020**	**05/10/2020**	**23/10/2020**	**19/11/2020**	**21/01/2021**	**18/03/2021**
Capo-Bianco, Ed	✓	✓	✓	Apols	Apols	✓	Apols	✓
Dickinson, Roger	✓	✓	✓	✓	✓	✓	✓	✓
Hedges, Diane	✓	✓	✓	✓	✓	✓	✓	✓
Kenworthy, Gareth	✓	✓	✓	✓	✓	✓	✓	✓
Smith, Duncan	✓	✓	✓	✓	✓	✓	✓	✓

Oxfordshire Primary Care Commissioning Committee

Name	07/05/2020	04/08/2020	08/12/2020
Azhar, Ansaf	Apols	Apols	Apols
Cogswell, Jo	✓	Apols	✓
Collison, Kiren	✓	✓	✓
Dickinson, Roger	✓	✓	✓
Hedges, Diane (on behalf of James Kent)	✓	✓	✓
Mountford, Catherine	✓	✓	✓
Paul, Meenu	✓	✓	✓
Smith, Duncan	✓	✓	✓

Quality Committee

Name	12/05/2020	14/07/2020	13/10/2020
Chapman, David	✓	✓	✓
Hedges, Diane	✓	✓	✓
Mountford, Catherine	✓	Apols	✓
Rooney, Guy	✓	✓	✓
Wallace, Louise	✓	Apols	✓
Wiltshire, Sula	✓	✓	✓

Remuneration Committee

Committee Member	14.04.2020 In Common	16/04/2020 Virtual	19/11/2020 In Common	11/12/2020	19/01/2021 Virtual In Common
Collison, Kiren	✓	N/A	N/A	N/A	N/A
Dickinson, Roger	✓	✓	✓	✓	✓

Smith, Duncan	✓	✓	✓	✓	✓
Wallace, Louise	✓	✓	✓	✓	N/A

NHS Oxfordshire Clinical Commissioning Group Annual Accounts 2020/21

Entity name:	NHS Oxfordshire Clinical Commissioning Group
This year	2020-21
Last year	2019-20
This year ended	31-March-2021
Last year ended	31-March-2020
This year commencing:	01-April-2020
Last year commencing:	01-April-2019

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The Primary Statements:

Statement of Comprehensive Net Expenditure for the year ended 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Income from sale of goods and services	2	(1,160)	(5,010)
Other operating income	2	(305)	(1,403)
Total operating income		**(1,465)**	**(6,413)**
Staff costs	4	6,839	6,649
Purchase of goods and services	5	1,081,327	956,544
Depreciation and impairment charges	5	232	248
Provision expense	5	(624)	511
Other Operating Expenditure	5	514	1,164
Total operating expenditure		**1,088,288**	**965,116**
Net Operating Expenditure		**1,086,823**	**958,703**
Net expenditure for the Year		**1,086,823**	**958,703**
Net (Gain)/Loss on Transfer by Absorption		0	0
Total Net Expenditure for the Financial Year		**1,086,823**	**958,703**
Comprehensive Expenditure for the year		**1,086,823**	**958,703**

The notes on pages 111 to 135 form part of this statement

Statement of Financial Position as at 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Non-current assets:			
Property, plant and equipment	8	181	414
Intangible assets	9	40	-
Total non-current assets		221	414
Current assets:			
Trade and other receivables	10	6,553	10,731
Cash and cash equivalents	11	0	0
Total current assets		**6,553**	10,731
Total current assets		**6,553**	10,731
Total assets		**6,774**	11,145
Current liabilities			
Trade and other payables	12	(68,776)	(65,862)
Borrowings	13	(1,049)	(1,227)
Provisions	14	(1,331)	(2,142)
Total current liabilities		**(71,156)**	(69,231)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(64,382)**	(58,086)
Non-current liabilities			
Total non-current liabilities		**0**	0
Assets less Liabilities		**(64,382)**	(58,086)
Financed by Taxpayers' Equity			
General fund		(64,382)	(58,086)
Total taxpayers' equity:		**(64,382)**	(58,086)

The notes on pages 111 to 135 form part of this statement

The financial statements on pages 107 to 110 were approved by the Board on 14th June 2021 and signed on its behalf by:

Accountable Officer
James Kent

Director of Finance
Gareth Kenworthy

Statement of Changes In Taxpayers Equity for the year ended 31 March 2021

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21				
Balance at 01 April 2020	(58,086)	0	0	**(58,086)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21				
Net operating expenditure for the financial year	(1,086,823)			**(1,086,823)**
Net funding	1,080,527	0	0	**1,080,527**
Balance at 31 March 2021	**(64,382)**	**0**	**0**	**(64,382)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2019-20				
Balance at 01 April 2019	(48,412)	0	0	**(48,412)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20				
Net operating costs for the financial year	(958,703)			(958,703)
Net funding	949,029	0	0	949,029
Balance at 31 March 2020	**(58,086)**	**0**	**0**	**(58,086)**

The notes on pages 111 to 135 form part of this statement

Statement of Cash Flows for the year ended 31 March 2021

	Note	**2020-21 £'000**	2019-20 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(1,086,823)	(958,703)
Depreciation and amortisation	8	232	248
(Increase)/decrease in trade & other receivables	10	4,179	2,631
Increase/(decrease) in trade & other payables	12	2,953	6,045
Provisions utilised	14	(187)	0
Increase/(decrease) in provisions	14	(624)	510
Net Cash Inflow (Outflow) from Operating Activities		**(1,080,270)**	(949,269)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		(39)	(89)
(Payments) for intangible assets		(40)	0
Net Cash Inflow (Outflow) from Investing Activities		**(79)**	(89)
Net Cash Inflow (Outflow) before Financing		**(1,080,349)**	(949,358)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		1,080,527	949,029
Net Cash Inflow (Outflow) from Financing Activities		**1,080,527**	949,029
Net Increase (Decrease) in Cash & Cash Equivalents	11	**178**	(329)
Cash & Cash Equivalents at the Beginning of the Financial Year		**(1,227)**	(898)
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**(1,049)**	(1,227)

The notes on pages 111 to 135 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2020-21 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis, in accordance with the definition as set out in Section 4 of the Department of Health and Social Care (DHSC) Group Accounting Manual 2020/21, which outlines the interpretation of IAS1 'Presentation of Financial Statements'. For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision (funding allocation) for that service in published documents, is normally sufficient evidence of going concern.

DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.

In carrying out its assessment, the Board has taken into account the following key considerations:

2021/22 to 2023/24 Indicative financial planning

The CCG has been notified formally of the level of allocations it will receive from the Department of Health, through NHS England, for the years 2021/22 to 2023/24 as per the table below:

£'000s	2019-20	2020-21	2021-22	2022-23	2023-24
Total notified allocation	932,422	969,811	996,571	1,036,547	1,076,780

NHS England has indicated that legislation may be passed during the 2021 calendar year to put Integrated Care Services (ICS's) on a statutory footing by 1 April 2022. CCGs will still be the statutory commissioners of NHS services until that point. The commissioning of health services (continuation of service) will continue after April 2022 but may be located in a different structure within the remit of the Department of Health. Mergers or a change to the NHS Structure, such as an ICS way of working, is not considered to impact on going concern.

Conclusion

Our considerations cover the period through to 30 June 2022, being 12 months beyond the date of authorisation of these financial statements. Taking into account these considerations and the governance structures in place both within the CCG and through the NHS E/I assurance process, the Board have a reasonable expectation that the CCG will have adequate resources to continue in operational existence for the foreseeable future. For this reason, we continue to adopt the going concern basis in preparing these financial statements.

1.2 Accounting Convention

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

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

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 BusinessCombinations. Where fundtions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

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

1.4 Joint arrangements

Arrangements over which the clinical commissioning group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the clinical commissioning group is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts. The CCG's Pooled Budgets are considered to be joint operations.

The clinical commissioning group has entered into a pooled budget arrangement with Oxfordshire County Council in accordance with section 75 of the National Health Service Act 2006. Under the arrangement, funds are pooled within a Better Care Fund (BCF) pool to provide services to adults with disabilities and older adults requiring health and social care. The Adults with Care and Support Needs (ACSN) pool is to provide health and social care services for adults with learning disabilities and children and adults with mental health problems. Note 16 provides details of the income and expenditure of the pools.

Notes to the financial statements

The pools are hosted by Oxfordshire County Council although the Mental Health element of the ACSN pool is hosted by Oxfordshire Clinical Commissioning Group. 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.

During the year, the County Council and the CCG have developed a new HESC (Health Education and Social Care) model for joint commissioning. The new governance structure went live from 1st April 2021 in the form of a new Joint Commissioning Executive (JCE). It is expected that a new Section 75 agreement will be enacted during 2021-22.

1.5 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

1.6 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:
• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

Main sources of revenue are recharges or one off income from NHS England, income from Oxfordshire County Council and recharges to other CCGs. Funding from NHS England is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

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

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 **Other Expenses**

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

1.9 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the clinical commissioning group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

Notes to the financial statements

1.10 **Property, Plant & Equipment**

1.10.1 **Recognition**

Property, plant and equipment is capitalised if:
· It is held for use in delivering services or for administrative purposes;
· It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
· It is expected to be used for more than one financial year;
· The cost of the item can be measured reliably; and,
· The item has a cost of at least £5,000; or,
· Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
· Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.10.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. The clinical commissioning group holds no assets that are subject to revaluation.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

1.10.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 **Intangible Assets**

1.11.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the clinical commissioning group's business or which arise from contractual or other legal rights. They are recognised only:

· When it is probable that future economic benefits will flow to, or service potential be provided to, the clinical commissioning group;
· Where the cost of the asset can be measured reliably; and,
· Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

1.11.2 **Measurement**

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.11.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Notes to the financial statements

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 **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.

1.12.1 **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.

1.13 **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.

1.14 **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:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.02% (2019-20: 0.51%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.18% (2019-20: 0.55%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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.

1.15 **Clinical Negligence Costs**

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

1.16 **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.

Notes to the financial statements

1.17 **Contingent liabilities and contingent assets**

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

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

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 amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.18.1 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

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.

1.20 **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 **Losses & Special Payments**

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

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

1.22 **Critical accounting judgements and 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. 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 regularly reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Notes to the financial statements

1.22.1 **Critical accounting judgements in applying accounting policies**

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

· The pooled budget arrangements, including the Better Care Fund, have been judged to be joint operations under IFRS 11 ie involve the contractually agreed sharing of control but not through a separate vehicle. The contractual arrangements (Section 75 agreements) establish the parties' rights to the assets, and obligations for the liabilities relating to the arrangement, and the parties' rights to the corresponding revenues and obligations to the corresponding expenses. Note 16 sets out the rights and obligations of the Clinical Commissioning Group in relation to the pooled arrangements.

· The CCG has judged that it acted as an agent, in accordance with IFRS 15, in the following circumstances: contributions from Oxfordshire County Council to the Mental Health element of the joint Adults with Care and Support Needs pool (which is hosted by OCCG); expenditure on prescribing and funded by Oxfordshire County Council Public Health; the cost of research performed by Oxford University and funded by receipts from the Department of Health; and expenditure on IT equipment for GP Practices/Flu vaccines funded by NHS England (see Notes 2 and 5).

1.22.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

· The Clinical Commissioning Group generates provisions to cover future liabilities of more than one year. Such provisions are estimated by management based on knowledge of the business and assumptions of probability. They are reviewed on an annual basis. The CCG's main provision £1.3m as at 31 March 2021 is in respect of Continuing Healthcare. This provision represents the Clinical Commissioning Group's share of the estimated liability to pay claims in respect of continuing care assessments. The provision is estimated from assessment of clients on the waiting list, average costs of care, average number of weeks that care is needed and average interest rates. Actual claims settled may differ from those calculated.

· Accruals are calculated based on management knowledge, market intelligence and contractual arrangements. The accruals cover areas such as prescribing, contracts for healthcare and non healthcare services. Estimates of partially completed spells and a maternity pathway prepayment are not required this year due to the nature of the block contracting arrangements in place in 2020-21 as part of the response to the pandemic. Prescribing accruals reflect the last two months of the financial year for which actual information is not available. They are based on forecasts received by the Business Services Authority amended to reflect the medicines management team's best assessment of pressures that may impact on the final position.

1.23 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2020-21. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – The Standard is effective 1 April 2022 as adapted and interpreted by the FReM.
● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

The impact of adopting IFRS 16 has been assessed. Leased assets will in future be disclosed on the SOFP subject to transitional arrangements set out in the FREM. There is one property lease that falls within the scope of the standard. If this had been accounted for in 2020-21, in accordance with IFRS 16 and using HM Treasury Discount rate of 0.91%, the CCG would have recognised a right of use asset of £2.8m and a lease liability of £2.8m in the SOFP. The impact on the SOCNE would have been an additional cost of approximately £10k for the first year.

2 Other Operating Revenue

	2020-21 Admin	2020-21 Programme	2020-21 Total	2019-20 Total
	£'000	£'000	£'000	£'000
Income from sale of goods and services (contracts)				
Non-patient care services to other bodies	0	393	**393**	4,260
Prescription fees and charges	0	767	**767**	750
Total Income from sale of goods and services	**0**	**1,160**	**1,160**	**5,010**
Other operating income				
Other non contract revenue	169	136	**305**	1,403
Total Other operating income	**169**	**136**	**305**	**1,403**
Total Operating Income	**169**	**1,296**	**1,465**	**6,413**

Note 2 excludes contributions from Oxfordshire County Council to the Mental Health element of the joint Adults with Care and Support Needs pool which is hosted by Oxfordshire Clinical Commissioning Group; receipts from the Department of Health for research performed by Oxford University; contributions by Oxfordshire County Council Public Health for prescribing; and contributions from NHS England for IT equipment for GP Practices and flu vaccines. In accordance with IFRS 15, the CCG is deemed to be acting as an agent.

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other	Prescription fees and charges
	£'000	£'000
Source of Revenue		
NHS	35	0
Non NHS	358	767
Total	**393**	**767**

	Non-patient care services to other bodies	Prescription fees and charges
	£'000	£'000
Timing of Revenue		
Point in time	393	767
Total	**393**	**767**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total Permanent Employees £'000	Other £'000	2020-21 Total £'000
Employee Benefits			
Salaries and wages	**4,747**	**706**	**5,453**
Social security costs	**514**	**0**	**514**
Employer Contributions to NHS Pension scheme	**862**	**0**	**862**
Apprenticeship Levy	**9**	**0**	**9**
Other post-employment benefits	**0**	**0**	**0**
Other employment benefits	**0**	**0**	**0**
Termination benefits	**0**	**0**	**0**
Gross employee benefits expenditure	6,133	706	6,839
Total - Net admin employee benefits including capitalised costs	6,133	706	6,839
Net employee benefits excluding capitalised costs	6,133	706	6,839

	Total Permanent Employees £'000	Other £'000	2019-20 Total £'000
Employee Benefits			
Salaries and wages	**4,488**	**805**	**5,293**
Social security costs	**494**	**0**	**494**
Employer Contributions to NHS Pension scheme	**851**	**0**	**851**
Apprenticeship Levy	**11**	**0**	**11**
Gross employee benefits expenditure	5,844	805	6,649
Total - Net admin employee benefits including capitalised costs	5,844	805	6,649
Net employee benefits excluding capitalised costs	5,844	805	6,649

The above costs include charges for staff who work for the Integrated Care System (ICS) and for whom contributions are received from other organisations.

Employee numbers note is part of remuneration section in the annual report.

4.2 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care 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:

4.2.1 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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.2.2 Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

For 2020-21, employers’ contributions of £862k (2019-20: £851k) were payable to the NHS Pension Scheme at the rate of 20.68% (2019-20: 20.68%) of pensionable pay.

5. Operating expenses

	2020-21 Admin £'000	2020-21 Programme £'000	2020-21 Total £'000	2019-20 Total £'000
Purchase of goods and services				
Services from other CCGs and NHS England	4,750	3,051	7,802	6,799
Services from foundation trusts	0	707,485	707,485	604,794
Services from other NHS trusts	0	5,967	5,967	7,459
Services from Other WGA bodies	0	0	0	1
Purchase of healthcare from non-NHS bodies	0	135,368	135,368	127,810
Prescribing costs	0	93,532	93,532	88,342
GPMS/APMS and PCTMS	0	113,641	113,641	106,573
Supplies and services – clinical	0	2,594	2,594	2,500
Supplies and services – general	93	6,639	6,732	7,963
Consultancy services	23	7	30	171
Establishment	178	1,000	1,178	1,099
Transport	0	0	0	3
Premises	564	5,960	6,524	2,578
Audit fees	85	0	85	83
Other professional fees	153	20	173	200
Legal fees	101	0	101	35
Education, training and conferences	24	92	116	133
Total Purchase of goods and services	**5,971**	**1,075,356**	**1,081,327**	**956,544**
Depreciation and impairment charges				
Depreciation	232	0	232	248
Total Depreciation and impairment charges	**232**	**0**	**232**	**248**
Provision expense				
Provisions	-	(624)	(624)	511
Total Provision expense	**-**	**(624)**	**(624)**	**511**
Other Operating Expenditure				
Chair and Non Executive Members	112	0	112	190
Grants to Other bodies	0	(20)	(20)	224
Research and development (excluding staff costs)	0	421	421	750
Other expenditure	1	0	1	0
Total Other Operating Expenditure	**113**	**401**	**514**	**1,164**
Total operating expenditure	**6,316**	**1,075,133**	**1,081,449**	**958,467**

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare

Note 5 excludes expenditure funded by contributions from Oxfordshire County Council to the Mental Health element of the joint Adults with Care and Support Needs pool which is hosted by Oxfordshire Clinical Group; expenditure on prescribing and funded by Oxfordshire County Council Public Health; the cost of research performed by Oxford University and funded by receipts from the Department of Health; and contributions from NHS England for IT equipment for GP Practices and flu vaccines. In accordance with IFRS 15, the CCG is deemed to be acting as an agent and therefore excludes the related expenditure (and revenue) from its accounts.

Note 5 includes expenditure incurred by the clinical commissioning group acting as the host for the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS). Oxfordshire Clinical Commissioning group receives allocations on behalf of the ICS which are then spent across the three counties in accordance with the priorities of the ICS. Allocations from NHS England totalling £16.5m were received in 20-21 on behalf of the ICS, of which £7.3m was transferred across the 3 CCGs leaving hosted ICS allocations of £9.2m within the CCG. Corresponding expenditure is mainly shown in Table 5 under Supplies and services – general and Services from other CCGs.

The External Audit fee for 2020-21 is £71k excluding VAT (2019-20 £70k).

6 Better Payment Practice Code

Measure of compliance	**2020-21 Number**	**2020-21 £'000**	2019-20 **Number**	2019-20 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	4,152	151,079	4,294	85,982
Total Non-NHS Trade Invoices paid within target	3,924	148,222	4,006	81,816
Percentage of Non-NHS Trade invoices paid within target	**94.51%**	**98.11%**	**93.29%**	**95.15%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,125	750,127	3,720	618,685
Total NHS Trade Invoices Paid within target	2,054	747,401	3,613	616,483
Percentage of NHS Trade Invoices paid within target	**96.66%**	**99.64%**	**97.12%**	**99.64%**

The Better Payment Practice Code requires the CCG 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 target for achievement is greater than 95%.

7. Operating Leases

7.1 As lessee

7.1.1 Payments recognised as an Expense		**2020-21**		2019-20
	Buildings £'000	**Total £'000**	**Buildings £'000**	**Total £'000**
Payments recognised as an expense				
Minimum lease payments	1,691	**1,691**	2,462	**2,462**
Total	**1,691**	**1,691**	**2,462**	**2,462**

Whilst our arrangements with NHS Property Services Limited fall within the definition of operating leases, the rental charges for future years have not yet been agreed. Consequently this note only includes future minimum lease payments for Jubilee House where future lease payments have been agreed.

The Clinical Commissioning Group occupies and pays rent on Jubilee House in Oxford. An Underlease was signed in March 2020 with NHS Property Services Limited and the agreement runs for 5 years from 2017 to November 2022. The minimum lease payments are shown below:

7.1.2 Future minimum lease payments		**2020-21**		2019-20
	Buildings £'000	**Total £'000**	**Buildings £'000**	**Total £'000**
Payable:				
No later than one year	343	**343**	403	**403**
Between one and five years	243	**243**	403	**403**
Total	**586**	**586**	**806**	**806**

8 Property, plant and equipment

2020-21	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2020	821	874	1,695
Additions purchased	0	0	0
Cost/Valuation at 31 March 2021	**821**	**874**	**1,695**
Depreciation 01 April 2020	578	704	1,282
Charged during the year	119	113	232
Depreciation at 31 March 2021	**697**	**817**	**1,514**
Net Book Value at 31 March 2021	**124**	**57**	**181**
Purchased	124	57	181
Total at 31 March 2021	**124**	**57**	**181**
Asset financing:			
Owned	124	57	181
Total at 31 March 2021	**124**	**57**	**181**

2019-20	Buildings excluding dwellings £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2019	250	693	624	1,567
Additions purchased	0	128	0	128
Reclassifications	(250)	0	250	0
Cost/Valuation at 31 March 2020	0	**821**	**874**	**1,695**
Depreciation 01 April 2019	100	482	452	1,034
Reclassifications	(100)	0	100	0
Charged during the year	0	96	152	248
Depreciation at 31 March 2020	**0**	**578**	**704**	**1,282**
Net Book Value at 31 March 2020	**0**	**243**	**170**	**413**
Purchased	0	243	170	413
Total at 31 March 2020	**0**	**243**	**171**	**413**
Asset financing:				
Owned	0	243	170	413
Total at 31 March 2020	**0**	**243**	**170**	**413**

8.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	5	20
Information technology	2	5
Furniture & fittings	5	10

9 Intangible non-current assets

2020-21	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2020	0	**0**
Additions purchased	40	**40**
Cost / Valuation At 31 March 2021	**40**	**40**
Amortisation 01 April 2020	0	**0**
Net Book Value at 31 March 2021	**40**	**40**
Purchased	40	**40**
Total at 31 March 2021	**40**	**40**

Microsoft N365 software was capitalised as intangible non-current assets during the year.

9.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	2	5

10.1 Trade and other receivables	Current 2020-21 £'000	Non-current 2020-21 £'000	Current 2019-20 £'000	Non-current 2019-20 £'000
NHS receivables: Revenue	52	0	230	0
NHS prepayments	0	0	1,837	0
NHS accrued income	51	0	52	0
NHS Non Contract trade receivable (i.e pass through funding)	199	0	1,575	0
Non-NHS and Other WGA receivables: Revenue	364	0	476	0
Non-NHS and Other WGA prepayments	784	0	1,415	0
Non-NHS and Other WGA accrued income	818	0	832	0
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	28	0	96	0
Expected credit loss allowance-receivables	(3)	0	(3)	0
VAT	51	0	29	0
Other receivables and accruals	4,208	0	4,192	0
Total Trade & other receivables	**6,552**	**0**	**10,731**	**0**
Total current and non current	**6,552**		**10,731**	
Included above:				
Prepaid pensions contributions	0		0	

10.2 Receivables past their due date but not impaired

	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000	2019-20 DHSC Group Bodies £'000	2019-20 Non DHSC Group Bodies £'000
By up to three months	20	6	756	3
By three to six months	47	19	0	0
By more than six months	92	339	338	2
Total	**159**	**364**	**1,094**	**5**

10.3 Loss allowance on asset classes	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 01 April 2020	(3)	0	**(3)**
Other changes	0	0	**0**
Total	**(3)**	**0**	**(3)**

11 Cash and cash equivalents

	2020-21 £'000	2019-20 £'000
Balance at 01 April 2020	(1,227)	(898)
Net change in year	178	(329)
Balance at 31 March 2021	**(1,049)**	**(1,227)**
Bank overdraft: Government Banking Service	(1,049)	(1,227)
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**(1,049)**	**(1,227)**
Balance at 31 March 2021	**(1,049)**	**(1,227)**

The overdraft in financial year 2020-21 relates to a timing difference of cash in transit. The Clinical Commissioning Group was contractually obliged to pay some suppliers of healthcare services on the 1st April 2021 so had to process a BACS payment run in March to achieve this. The overdraft is disclosed as borrowing in Note 13 and in the Statement of Financial position.

The Clinical Commissioning Group does not hold any patients' money.

12 Trade and other payables	**Current 2020-21 £'000**	**Non-current 2020-21 £'000**	Current 2019-20 £'000	Non-current 2019-20 £'000
NHS payables: Revenue	7,629	0	11,292	0
NHS accruals	3,799	0	6,613	0
Non-NHS and Other WGA payables: Revenue	6,533	0	3,686	0
Non-NHS and Other WGA payables: Capital	13	0	51	0
Non-NHS and Other WGA accruals	25,326	0	22,681	0
Non-NHS and Other WGA deferred income	111	0	152	0
Social security costs	74	0	79	0
Tax	62	0	69	0
Payments received on account	0	0	3	0
Other payables and accruals	25,229	0	21,236	0
Total Trade & Other Payables	**68,776**	**0**	**65,862**	**0**
Total current and non-current	**68,776**		**65,862**	

Other payables includes £13.5m outstanding payments to GP practices/other similar entities, £6.7m outstanding payments for Hosted BOB ICS entities, £2.5m representing the CCGs share of the pooled budget current liabilities, £1.9m for Other Acute and Community Health entities and £0.9m outstanding pension contributions at 31 March 2021.

13 Borrowings	**Current 2020-21 £'000**	**Non-current 2020-21 £'000**	**Current 2019-20 £'000**	**Non-current 2019-20 £'000**
Bank overdrafts:				
· Government banking service	1,049	0	1,227	0
· Commercial banks	0	0	0	0
Total overdrafts	**1,049**	**0**	**1,227**	**0**
Total Borrowings	**1,049**	**0**	**1,227**	**0**
Total current and non-current	**1,049**		**1,227**	

13.1 Repayment of principal falling due

	Department of Health 2020-21 £'000	**Other 2020-21 £'000**	**Total 2020-21 £'000**
Within one year	1,049	0	1,049
Between one and five years	**1,049**	**0**	**1,049**
Total	**1,049**	**0**	**1,049**

The overdraft in financial year 2020-21 relates to a timing difference of cash in transit. The Clinical Commissioning Group was contractually obliged to pay some suppliers of healthcare services on the 1st April 2021 so had to process a BACS payment run in March to achieve this. The overdraft is disclosed as borrowing in this note and in the Statement of Financial position

14 Provisions

	Current 2020-21 £'000	Current 2019-20 £'000
Continuing care	1,331	2,142
Total current and non-current	**1,331**	**2,142**

	Continuing Care £'000	**Total £'000**
Balance at 01 April 2020	**2,142**	**2,142**
Arising during the year	548	**548**
Utilised during the year	(187)	**(187)**
Reversed unused	(1,172)	**(1,172)**
Balance at 31 March 2021	**1,331**	**1,331**
Expected timing of cash flows:		
Within one year	1,331	**1,331**
Balance at 31 March 2021	**1,331**	**1,331**

Legal claims are calculated from the number of claims currently lodged with the NHS Litigation Authority and the probabilities provided by them. There were no legal claims outstanding at 31 March 2021 (31 March 2020 £0).

There are no provisions included by the NHS Litigation Authority as at 31 March 2021 in respect of clinical negligence liabilities of the clinical commissioning group (31 March 2020: £0).

The provision for Continuing Care is the Clinical Commissioning Group's estimated liability to pay claims in respect of continuing care assessments.

15 Financial instruments

15.1 Financial risk management

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

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

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

15.1.1 Currency risk

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

15.1.2 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.

15.1.3 Credit risk

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

15.1.4 Liquidity risk

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

15.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

15 Financial instruments cont'd

15.2 Financial assets

	Financial Assets measured at amortised cost 2020-21 £'000	Equity Instruments designated at FVOCI 2020-21 £'000	Total 2020-21 £'000
Trade and other receivables with NHSE bodies	77	0	77
Trade and other receivables with other DHSC group bodies	1,016	0	1,016
Trade and other receivables with external bodies	4,627	0	4,627
Total at 31 March 2021	**5,720**	**0**	**5,720**

15.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2020-21 £'000	Other 2020-21 £'000	Total 2020-21 £'000
Loans with external bodies	1,049	0	**1,049**
Trade and other payables with NHSE bodies	2,082	0	**2,082**
Trade and other payables with other DHSC group bodies	11,400	0	**11,400**
Trade and other payables with external bodies	55,048	0	**55,048**
Total at 31 March 2021	**69,579**	**0**	**69,579**

16 Operating segments

The Clinical Commissioning Group and consolidated group consider they have only one segment: that being commissioning of healthcare services.

17 Joint arrangements - interests in joint operations

The NHS Clinical Commissioning Group shares of the income and expenditure handled by the pooled budgets in the financial year were:

	2020-21	2019-20
	£'000	£'000
Income	175,406	171,520
Expenditure	(175,406)	(171,520)

The Clinical Commissioning Group has pooled budget arrangements with Oxfordshire County Council covering two pooled budgets. The Better Care Fund (BCF) pool includes services for Continuing Health Care (CHC) which cover both adults of working age and older adults. The Adults with Care and Support Needs (ACSN) pool includes services for Mental Health and Learning Disability and also Acquired Brain Injury (ABI). The pooled budgets are joint operations as defined by IFRS 11 ie the arrangements are jointly controlled by the Clinical Commissioning Group and by Oxfordshire County Council. Each pool is subject to different risk share arrangements which take into account both the percentage contribution from each party as well as the risk inherent within the services.

A large proportion of the Mental Health element of the ACSN pool comprises an Outcome Based Contract (OBC) with Oxford Health NHS FT which exists as a block contract apart from the Adult Social Care element. There are some clients who do not fit the criteria for the OBC and whose costs sit within the ACSN pool but outside the OBC. Any over or underspend in this area is split 50:50 between the partners after having made good a £200k budget reduction by OCC. The Acquired Brain Injury (ABI) over or underspend was taken by the relevant partner. All other over or underspends were taken 100% by OCC.

During the year, the County Council and the CCG have developed a new HESC (Health Education and Social Care) model for joint commissioning. The new governance structure went live from 1st April 2021 in the form of a new Joint Commissioning Executive (JCE). It is expected that a new Section 75 agreement will be enacted during 2021-22

17 Joint arrangements - interests in joint operations cont'd

BETTER CARE FUND POOLED BUDGET

The Better Care Fund pooled budget is hosted by Oxfordshire County Council (OCC). The Clinical Commissioning Group makes contributions to the pool, which are then used to purchase healthcare services. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement. In 2020-21 any over or underspends on this pool were not risk shared but were aligned ie they accrued to the partner to whom they related.

Funds are pooled under S75 of the Health Act 2006 for Older People and Continuing Care Services. The Better Care Fund (BCF) is a national programme spanning both the NHS and local government. Oxfordshire Clinical Commissioning Group account for the BCF as a joint operation under IFRS 11 as part of the Better Care Fund pooled budget arrangement.

BETTER CARE FUND MEMORANDUM of ACCOUNT for the year ending 31 March 2021

	Total Contributions £'000
Partner Contributions	
Oxfordshire Clinical Commissioning Group	96,431
Oxfordshire CC Social & Community Services Directorate	101,126
Total Funding	197,557
Total Expenditure	197,557
Net (Under)/Overspend	0

Balance Sheet

The following balances are included in the Statement of Financial Position and relate to the pooled budget. These balances have been derived from the pooled budget agreement.

	31 March 2021 CCG £'000
CURRENT ASSETS	
Debtors - Amounts falling due within 1 year	
Other prepayments and accrued income	2,611
TOTAL CURRENT ASSETS	2,611
Creditors - Amounts falling due within 1 year	
Accruals and deferred income	(1,813)
NET CURRENT ASSETS / (LIABILITIES)	798
Provisions for Liabilities & Charges	(798)
TOTAL ASSETS EMPLOYED	0
FINANCED BY:	
TAXPAYERS' EQUITY	
Reserve	0
TOTAL TAXPAYERS' EQUITY	0

17 Joint arrangements - interests in joint operations cont'd

ADULTS WITH CARE AND SUPPORT NEEDS POOLED BUDGET

The Mental Health and Autism elements of the ACSN pool are hosted by Oxfordshire Clinical Commissioning Group with Oxfordshire County Council hosting the Learning Disability element. The Clinical Commissioning Group makes contributions to the pool, which are then used to purchase healthcare services. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement. The risk share arrangements were a 50:50 share of over or underspends on Adult Social Care clients who fall outside the Outcome Based Contract (OBC) after having made good a £200k budget reduction by OCC.The Acquired Brain Injury over or under spend was taken by the relevant partner. All other over or underspends were taken 100% by OCC.

ADULTS WITH CARE AND SUPPORT NEEDS MEMORANDUM of ACCOUNT for the year ending 31 March 2021

	Total Contributions £'000
Partner Contributions	
Oxfordshire CCG	77,019
Oxfordshire CC Social & Community Services Directorate	96,430
Total Funding	**173,449**
Total Expenditure	173,449
Net (Under)/Overspend	**0**

Balance Sheet

There are no balances included in the Statement of Financial Position that relate to the ACSN pooled budget. All balances are shown in the accounts of Oxfordshire County Council.

18 Related party transactions

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority and,
- NHS Business Services Authority.

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Oxfordshire County Council in respect of joint enterprises.

Details of related party transactions with related entities are as follows:

Related Party	Payments to Related Party £'000	Amounts owed to Related Party £'000	Receipts from Related Party £'000	Amounts due from Related Party £'000
Age UK Oxfordshire	413	0	0	0
Buckinghamshire Healthcare NHS Trust	13,081	0	0	30
Great Western Hospitals NHS Foundation Trust	4,618	0	0	0
NHS Berkshire West CCG	1,610	532	579	16
NHS Buckinghamshire CCG	2,004	372	3,586	16
OXFED Federation	2,958	0	0	0
Oxford Health NHS Foundation Trust	193,521	0	0	0
Oxford University Hospitals NHS Trust	450,613	283	173	8
Oxfordshire County Council	113,046	0	10,695	227
Oxfordshire LMC	230	0	0	0
Principal Medical Limited	6,889	0	0	0
Royal Berkshire Foundation Trust	30,842	0	0	62
SEOX Ltd	665	0	0	0

18 Related party transactions cont'd

Name	Title	Relationship	Related Party
Dr Ansaf Azhar	Director of Public Health for Oxfordshire (non-voting)	Pooled budgets with NHS	OCC Pooled Budgets
Stephen Chandler	OCC Director of Adult Services (non-voting)	Pooled budgets with NHS	OCC Pooled Budgets
Dr Ed Capo-Bianco	Portfolio Clinical Director	GP Partner	Goring & Woodcote Medical Practice
		Wife Salaried GP	Woodlands Medical Centre
		Practice Shareholder	Principal Medical Limited
		Practice is a member	SEOX Federation
		Director	Red Kite Shop Ltd
		Practice is a member	Primary Care Network - OPCN12 Wallingford and Surrounds
Dr David Chapman	Portfolio Clinical Director	Partner and part owner	Hollow Way Medical Centre
		Practice is a member / Practice Partner is a Director	OXFED Federation
		Wife Advisor Manager	Oxford Citizents Advice Bureau
		Undertakes work - paid via practice	Oxford Health NHS Foundation Trust - Learning Disability Services
		Practice is a member	Primary Care Network OPCN09 SEOxHA
		Director	Kays Electronics Limited
Jo Cogswell	Director of Transformation	None	None
Dr Kiren Collison	Clinical Chair (voting)	Sessional GP	Nuffield Health Centre
		Partner employee	Oxford University Hospitals NHS Foundation Trust
		Board member	NHS Clinical Commissioners
		Practice is a member	Primary Care Network - OPCN18 Eynsham and Witney
		Director	Indigo Silver Neuroimaging
		Seconded as interim Deputy Medical Director of Primary Care	NHS England / Improvement
Heidi Devenish	Practice Manager Representative (non-voting)	Business Practice Manager	Summertown Health Centre
		Husband Director of Pharmacy & Medicines Optimisation, Associate Deputy Director for Diagnostics and Outpatients Division, Trust Controlled Drug Accountable Officer	Great Western Hospitals NHS Foundation Trust
		Director	Orchard Grove (Yarnton) Management Limited
		Practice is a member	Primary Care Network - Healthier Oxford City Network
Roger Dickinson	Lay Member Lead for Governance and Vice Chair (voting)	None	None
Dr Sam Hart	Network Clinical Director	GP Partner	Islip Medical Practice
		Champion for Parkrun (Islip is a Parkrun Practice, SH is nominated GP)	Parkrun
		Practice is a member of OPCN04 Kidlington, Islip, Woodstock and Yarnton (KIWY)	Primary Care Network
		Medical Referee paid to verify administrative details of people due for cremation; paid by Memoria who own crematorium	North Oxford Crematorium
Dr Shelley Hayles	Portfolio Clinical Director	Employee	Thames Valley Cancer Alliance
Diane Hedges	Chief Operating Officer and Deputy Chief Executive	Director	Diane Hedges Ltd
		Niece employed by the Children and Adolescent Mental Health Service (CAMHS)	Oxford Health NHS Foundation Trust
		Chair of the Joint Project Board	Integrated Respiratory pilot Project (Boehringer Ingelheim Repiratory Project)
Dr James Kent	Accountable Officer and Executive ICS Lead Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System	Wife is employed as a senior Pharmacist	Hall Practice and Chalfonts PCN
		John Storey, Porthaven Chief Executive, is a friend	Porthaven
		Director	Curzon Partners Ltd
		Member of the Committee	The Royal Foundation COVID-19 Grant Response Fund Committee
Gareth Kenworthy	Director of Finance (voting)	Director	Oxfordshire Infracare LIFT
		Member of the Council of Governors	Oxford University Hospitals NHS Foundation Trust
		Member of the Joint Project Board	Integrated Respiratory pilot Project (Boehringer Ingelheim Repiratory Project)
		Wife provides sports therapy services under the 'Generation Games' contract OCCG has with Age UK	Age UK Oxfordshire
		Son is working at BHT via NHS Professionals. This is while on his placement year from university	NHS Professionals / Buckinghamshire Healthcare NHS Trust
		2 day per week secondment as ICS Finance Lead	Integrated Care System (ICS)
Catherine Mountford	Director of Governance and Business Process (non-voting)	Daughter works on the Oxford University Hospitals NHS Foundation Trust Helpdesk	Bouygues UK
Dr Guy Rooney	Medical Specialist Adviser (voting)	Consultant	Great Western Hospitals NHS Foundation Trust
		Member	Thames Valley Clinical Senate
		Medical Director	Oxford Academic Health Science Network (AHSN)
		Steering Group Member	NHS Benchmarking Network
Duncan Smith	Lay Member (voting)	Partner	Dudley Smith Limited Management Consultants
Dr Andy Valentine	Network Clinical Director	Salaried GP	Dr Leaver and Partners
		Wife employed as an anaesthetist	Royal Berkshire NHS Fountation Trust
		Practice is a member of OPCN07 Oxford Central	Primary Care Network
Professor Louise Wallace	Lay Representative - Patient and Public Involvement	Managing Director and Shareholder	Health Behaviour Research Consultancy Ltd
		Lay Member Fitness to Practice Panel	General Dental Council
		Director and Trustee	UK Public Health Register
		Part-time Professor of Psychology and Health	Open University
		Lay Adjudicator	Social Work England Fitness to Practice Tribunals
Sula Wiltshire	Registered Nurse on the Governing Body (Board) (voting)	Member of Council of Governors	Oxford Health NHS Foundation Trust
		Daughter employee	Oxford University Hospitals NHS Foundation Trust

18 Related party transactions cont'd

Oxfordshire CCG Practices	Payment to Related Party £
ABINGDON SURGERY	1,789,547
BAMPTON MEDICAL PRACTICE	1,027,604
BANBURY ROAD MEDICAL CENTRE	875,839
BARTLEMAS SURGERY	1,271,063
BEAUMONT STREET SURGERY	567,542
BELL SURGERY	1,173,308
BERINSFIELD HEALTH CENTRE	119,792
BICESTER HEALTH CENTRE CONSORTIUM	35,455
BLETCHINGTON ROAD SURGERY	1,701,051
BLOXHAM & HOOK NORTON SURGERIES	1,646,947
BOTLEY MEDICAL CENTRE	1,747,825
BROADSHIRES HEALTH CENTRE	1,297,237
BROOK & CHILTERN SURGERY (THE)	17,803
BURY KNOWLE HEALTH CENTRE	3,753,391
CHARLBURY MEDCIAL CENTRE	721,576
CHILTERN SURGERY	977,705
CHIPPING NORTON HEALTH CENTRE	3,280,543
CHURCH STREET PRACTICE	1,997,073
CLIFTON HAMPDEN SURGERY	2,991
COGGES SURGERY	833,775
COKER CLOSE HEALTH CENTRE	2,128,483
COWLEY ROAD MEDICAL PRACTICE	31,335
CROPREDY SURGERY	1,098,300
DEDDINGTON HEALTH CENTRE	7,816
DIDCOT HEALTH CENTRE	2,084,500
DONNINGTON MEDICAL PARTNERSHIP (THE)	1,530,589
DR A MURPHY & PARTNERS	2,190,618
DR B J BATTY & PARTNERS	161,876
DR BRYSON & PARTNERS	72,742
DR HAMMERSLEY & PARTNERS OXFORD	747,156
DR KENYON & PARTNERS	1,592,904
DR T W ANDERSON & PARTNERS	2,092,529
EARLS LANE HEALTH CENTRE	2,744,747
EAST OXFORD HEALTH CENTRE STEVENS	1,283,805
EYNSHAM MEDICAL CENTRE	2,727,665
FANE DRIVE HEALTH CENTRE	650,970
GORING & WOODCOTE MEDICAL PRACTICE	2,182,846
GOSFORD HILL MEDICAL CENTRE	874,102
HART SURGERY	1,350,275
HERTS URGENT CARE	120
HIGHTOWN SURGERY	1,326,009
HOLLOW WAY MEDICAL CENTRE	1,070,172
HORSEFAIR SURGERY	173,044
HURLEY CLINIC	428
HURLEY GROUP	86
ISLIP MEDICAL PRACTICE	8,146
JERICHO HEALTH CENTRE KEARLEY	1,164,759
JERICO HEALTH CENTRE BOGDANOR	787,363
KEY MEDICAL PRACTICE	1,416,430
KING EDWARD STREET SURGERY	645,786
LEYS HEALTH CENTRE	1,993,759
LONG FURLONG MEDICAL CENTRE	964,554
LUTHER STREET MEDICAL CENTRE	5,858
MALTHOUSE SURGERY	2,095,935
MANOR SURGERY	2,052,833
MARCHAM ROAD HEALTH CENTRE	2,172,777
MILL STREAM SURGERY	677,266
MONTGOMERY-HOUSE SURGERY	179,760
MORLAND HOUSE SURGERY	2,314,252
NETTLEBED SURGERY	1,201,067
NEWBURY STREET PRACTICE	1,902,686
NUFFIELD HEALTH CENTRE	2,003,439
OAK TREE HEALTH CENTRE	1,043,271
OBSERVATORY MEDICAL PRACTICE	4,826
ROBIN LANE MEDICAL CENTRE	108
RYCOTE PRACTICE	1,436,188
SHEEP STREET SURGERY BURFORD	1,206,499
SIBFORD SURGERY	552,758
SONNING COMMON HEALTH CENTRE	1,592,506

Oxfordshire CCG Practices	Payment to Related Party £
SOUTH OXFORD HEALTH CENTRE	1,335
ST BARTHOLOMEWS MEDICAL CENTRE	2,469,478
ST CLEMENTS SURGERY OXFORD	553,731
SUMMERTOWN HEALTH CENTRE	1,569,721
TEMPLE COWLEY HEALTH CENTRE	1,028,203
VERNOVA HEALTHCARE CIC	61
WALLINGFORD MEDICAL PRACTICE	2,474,117
WATERY LANE SURGERY	775,906
WEST BAR SURGERY	4,580,438
WHITE HORSE MEDICAL CENTRE	3,197,415
WHITE HORSE PRACTICE	278,848
WINDRUSH MEDICAL PRACTICE WITNEY	2,867,332
WINDRUSH SURGERY BANBURY	1,096,770
WOODLAND SURGERY BANBURY	865,162
WOODLANDS MEDICAL CENTRE	1,503,671
WOODSTOCK SURGERY	1,166,132
WYCHWOOD SURGERY	1,188,974

Oxfordshire CCG PCNs	Payment to PCN £
ABINGDON AND DISTRICT PCN	233,787.18
ABINGDON CENTRAL PCN	277,181.20
BANBURY ALLIANCE PCN	151,634.17
BANBURY CROSS PCN	317,809.19
BICESTER PCN	511,562.00
CITY - EAST OXFORD PCN	397,875.55
CITY - OX3+ PCN	505,011.76
DIDCOT PCN	379,255.51
EYNSHAM & WITNEY PCN	504,298.68
HEALTHIER OXFORD CITY NETWORK	353,949.67
HENLEY SONNET PCN	292,277.22
KIDLINGTON, ISLIP, WOODSTOCK & YARNTON (KIWY) PCN	359,647.37
NORTH OXFORDSHIRE RURAL ALLIANCE (NORA) PCN	342,562.62
OXFORD CENTRAL PCN	208,041.09
RURAL WEST OXFORDSHIRE PCN	202,643.62
SOUTH EAST OXFORD HEALTH ALLIANCE (SEOxHA) PCN	395,360.04
THAME PCN	275,327.65
WALLINGFORD & SURROUNDS PCN	232,990.59
WANTAGE PCN	303,615.00
WHITE HORSE BOTLEY PCN	356,951.01

GP practices within the area have joined other professionals in the Clinical Commissioning Group in order to plan, design and pay for services. Under these arrangements some services are designed to be delivered in a primary care setting. This involves paying GP practices and Primary Care Networks for the delivery of these services. A GP is also paid by the Clinical Commissioning Group for taking a lead role on clinical services. All such arrangements are in the ordinary course of business and follow the CCGs strict governance and accountability arrangements. Material transactions are disclosed appropriately in the accounts.

19 Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the Clinical Commissioning Group.

20 Financial performance targets

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

	2020-21 Target	**2020-21 Performance**	**Duty Achieved?**	2019-20 Target	2019-20 Performance	Duty Achieved?
Expenditure not to exceed income	1,088,564	1,088,329	**Yes**	965,263	965,244	Yes
Capital resource use does not exceed the amount specified in Directions	40	40	**Yes**	128	128	Yes
Revenue resource use does not exceed the amount specified in Directions	1,087,059	1,086,823	**Yes**	958,722	958,703	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	**Yes**	0	0	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	**Yes**	0	0	Yes
Revenue administration resource use does not exceed the amount specified in Directions	13,172	12,854	**Yes**	14,892	12,683	Yes

For the purposes of this note 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, and included here on a gross basis).