NHS
Oxfordshire
Clinical Commissioning Group

NHS Oxfordshire Clinical Commissioning Group: Annual Report 2017/18

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Foreword

We are delighted to present the annual report and accounts for 2017/18. During the year we have made real progress in the way healthcare is delivered in the county. This work includes supporting a more sustainable primary care; achieving better diabetes outcomes; pioneering a new approach to cancer detection and we have extended mental health support for people with long term conditions to help them manage depression and anxiety associated with their condition.

Yet we must do more. With the demand for health and social care services increasing year on year and the challenges we face to keep pace with this, we need to work differently going forward.

We both took up our new roles with OCCG at the start of 2018 and we are positive about the opportunities for improving health and care for Oxfordshire patients. We strongly believe that patients and the public are at the centre of what we do. By moving to a more place-based approach for health and care planning, whereby local health needs and facilities are identified, we look forward to working alongside patients and their families to help shape services.

We are also committed to working better together with all our partners across the system, including social care. With this approach, we will strive to keep people living well and independent for longer and to offer seamless, high quality care in the right place and at the right time when it is needed.

We look forward to the year ahead.

Dr Kiren Collison
Clinical Chair

Louise Patten
Chief Executive

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.

Oxfordshire Clinical Commissioning Group's vision

Performance Overview

Oxfordshire Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group (OCCG) is the statutory organisation in Oxfordshire that plans, buys and oversees health services for more than 720,000 people from a range of NHS, voluntary, community and private sector providers. OCCG was established in April 2013 and took over this responsibility from Oxfordshire Primary Care Trust.

These services include hospital services, mental health services, ambulance services, GP services, community services such as district nursing and physiotherapy. We do this on behalf of people registered at GP practices in Oxfordshire and those who live in Oxfordshire (but not registered with a GP practice). To do this successfully, we work with local people, GPs, hospital and community service providers and other partners including local government and organisations within the voluntary sector. OCCG is a member organisation of 70 GP practices in Oxfordshire.

The National Health Service Act 2006 (as amended) sets out a number of duties on NHS organisations. For clinical commissioning groups the duty is to improve the quality of services commissioned; reduce health inequalities; involve the public and patients in commissioning decisions and deliver a Health and Wellbeing (HWB) Strategy. This Annual Report describes how we comply with the Act.

OCCG's work is guided by our Five Year Strategic Plan, 2014/15 – 2018/19, which directly supports delivery of the HWB strategy, a joint strategy to improve the health and wellbeing of local people and reduce health inequalities[1] across the county (see page 34 for more details). OCCG's strategy was developed in 2014 with input from the public and our partners.

OCCG will be working towards a new health and social care system strategy that is being developed with partners and wider engagement.

1People can experience health inequalities due to a combination of factors, including their life circumstances and where they live. People experiencing inequalities generally live significantly fewer years than those with less disadvantaged circumstances or those living in more affluent areas. They also generally tend to experience poorer health.

Oxfordshire's Population and how this is changing[2]

Over the ten year period from 2006 and 2016, there was an 8.3% overall growth in the population of Oxfordshire, similar to the increase across England (8.4%). The five-year age band with the greatest increase over this period was the newly retired age group 65 to 69 (+41%). There was a decline in the population aged 35 to 44.

Based on expected housing growth, Oxfordshire's population is predicted to continue to increase by 27% between 2016 and 2031. The growth is expected to include a 55% increase in the number of people over aged 85 and over and most people in Oxfordshire are from a White British background; however, the county is becoming more ethnically diverse. The Census 2011 survey remains the most detailed source of data on ethnicity and shows that residents of Oxfordshire from an ethnic minority background make up 16% of the population. This was lower than the national average of 20%.

As a whole, people living in Oxfordshire enjoy a relatively good quality of life with higher than average earnings and low rates of unemployment compared with many other parts of the country.

Despite relative affluence, income deprivation is an issue in urban and rural areas. Poverty and deprivation remain an issue in Oxfordshire affecting 14,000 children and 13,500 older people. Snapshot data (Aug 2014) from Her Majesty's Revenue & Customs shows almost 1 in 5 children aged 0-15 in Oxford were living in low income families. There has also been an increase in people presenting as homeless and in priority need in Oxfordshire in the past six years, rising from 457 in 2011/12 to 482 in 2016/17.

Oxfordshire is a relatively rural county. As of mid-2016 a third of the total population of Oxfordshire lived in areas defined as 'rural' by the Office for National Statistics (ONS). Older people are more likely to live in rural areas than younger age groups and West Oxfordshire has the highest proportion living in rural areas and the highest proportion of older rural residents.

Levels of disability (defined as those experiencing physical, mental, cognitive, learning, social, behavioural or other types of impairment) are low in Oxfordshire, compared to national averages, but vary significantly by age and by district. Oxfordshire has a slightly higher proportion of people aged over 85 with a disability when compared with the South East of England (81.1% versus 80.6%, 2011 Census). In the younger age groups, rates of disability in Oxfordshire are similar to or below the regional and national averages.

Oxfordshire's residents tend to be relatively healthy compared with other parts of the country and there has been a significant increase in the proportion of people

[2] Oxfordshire Joint Strategic Needs Assessment 2018 published June 2018

participating in sport (Active People Survey of Oct 2012 - Oct 2013 and Apr 2015 - March 2016). However in the 2016/17 academic year, a measure of prevalence of sever obesity was introduced. In Oxfordshire, 1.4% of reception year children were severely obese. In year 6, this had increased to 3.4% of children classified as severely obese.

Common health conditions experienced by residents include high blood pressure (89,000 patients), depression (56,800 patients) asthma (42,200 patients) and diabetes (29,500 patients); this is similar to areas across England (Quality & Outcomes Framework data).

People are more likely to discuss their mental health with a GP and to access treatment. The number and rate of people in Oxfordshire recorded with depression or anxiety has increased significantly each year for the past four years. Between 2015/16 and 2016/17 the number of patients with diagnosed depression in Oxfordshire increased by 14%.

The use of health services is increasing both in overall terms and when measured per person both in Oxfordshire and nationally. A sample of GP practices in Oxfordshire by OCCG shows that the number of consultations per person aged 80+ doubled between 2009/10 and 2013/14. The 2017 GP Patient survey shows that 67% of respondents in the Oxfordshire had seen or spoken to a GP within the last six months. This was similar to the rate for England (68%). There has also been an increase in the number of people referred for treatment to mental health services, particularly children and young people.

The leading cause of death in Oxfordshire is cancer (for the combined years 2014, 2015 and 2016), accounting for 28% of deaths of mean and 23% of deaths of women. The second highest cause for men was heart diseases (13%) and for women, dementia and Alzheimer disease (17% of deaths). Between 2013/15 and 2014/6, the life expectancy for men and women in Oxfordshire increased. For men the increase was from 81.2 years to 81.4 years and for women it was from 84.3 years to 84.6 years. The gap between male and female life expectancy in Oxfordshire also decreased, from 4.1 years to 3.2 years (Office for National Statistics). This change in life expectancy contributed to an increase in the proportion of men in the older age groups in Oxfordshire.

The information above is taken from the Joint Strategic Needs Assessment for Oxfordshire 2018 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 the OCCG's strategy and supports our service planning and decision-making. To read more about the health needs of Oxfordshire's population visit Oxfordshire County Council website: http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment.

Overview of Performance from Louise Patten – Chief Executive

Like many areas across England, Oxfordshire continues to face unprecedented demand on its services. We have a growing number of older people living in the county, many of whom are living with one or more long term chronic conditions. New housing developments mean that at the same time more people are moving into the county and we are facing real challenges recruiting high quality NHS staff and maintaining high quality buildings and facilities.

In addition to the everyday work of ensuring current services are of the highest quality, in the past year a considerable amount of work has been undertaken with clinicians and members of the public, as part of our change programme, to see how we can change healthcare services making them sustainable and affordable for the future. This work included a continued focus on a long term change programme to tackle the many challenges facing the NHS. During the early part of 2017/18 OCCG completed a public consultation and then made decisions about changing a number of services in Oxfordshire. The report on the consultation was published in June 2017, followed by final proposals and decisions being made by OCCG Board in August 2017. These changes were needed to ensure quality and safety improvements could be made but it was acknowledged that some of the changes were unpopular. Please see page 16 for more detail.

During the year, we have been working with GP practices to improve access to services and improve the quality of services for patients. A Primary Care Framework was published, setting out our vision and approach for improving primary care. GP practices have worked together in the six localities to use the framework and develop plans for strengthening primary care services. These plans discussed with patients and the public; they include a number of initiatives that together will mean patients will have a wider range of services available in primary care. Patients living with long term conditions will be better supported with more care provided closer to home and the risk of emergency admission to hospital will be reduced.

Our hospital providers have struggled to meet the waiting time targets for patients being referred and treated within 18 weeks and this continues to be a challenge; OCCG continues to monitor this carefully.

At the same time, the system has not met the A&E 4 hour wait target despite a number of initiatives and campaigns to support people staying well during the winter months and providing alternatives to A&E. Investments to support patients being discharged from hospital and to avoid the need for a hospital admission have helped but the steady increase in emergency admissions continues to challenge the whole health system.

Improving the quality of services provided in Oxfordshire and outcomes for people is a major part of our work. We continue to monitor our services to ensure we can act when things are not working well.

We are in the third year of a seven year outcomes based contract for adults with mental illness. The services provided aim to improve mental health outcomes for adults, bringing together in-patient, community psychiatry and psychology, housing and support, recovery services, employment support and a wellbeing service.

We have also achieved financial plans with total funding for the year 2017/18 of £872.5m. This funding is used to commission health services to meet the needs of the population of Oxfordshire. The population is relatively affluent with pockets of deprivation in urban areas (particularly Oxford and Banbury) and in rural areas. Approximately one third of the population of Oxfordshire live in areas defined as rural with older people more likely to live in rural parts of the county. While the amount of money we receive for the NHS locally is increasing year on year, the cost of delivering services and the demand for services are growing at a faster rate.

On a personal note, I joined OCCG in January 2018 soon after Dr Kiren Collison took up the position of Clinical Chair. Since then, together we have been setting out a new way forward for OCCG and the wider Oxfordshire health system. We know that we can be more effective at tackling some of the long standing challenges in Oxfordshire by working together – with our partners in local authorities, those responsible for providing services locally and with patients and the public. We have shared our intention to work with localities to develop plans for how services should develop in the future. This will feature in the coming year.

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 that can hamper OCCG's ability to achieve our 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 sub-committee meetings including the Audit Committee, the Finance Committee, the Oxfordshire Primary Care Commissioning Committee and the Quality Committee. In addition to the above Board Committees, OCCG directors review all risks in the directors' risk review on a monthly basis. The report on OCCG's strategic and operational risks as of 31 March 2018 can be found on OCCG website here.

The table below outlines OCCG's principal risks, showing mitigating measures as at 31 March 2018; further information is available at the above link.

Risk	**Update on mitigation**
There is a risk that current ways of working across the health and social care system in Oxfordshire are not efficient and effective; this dilutes priorities and doesn't deliver	All key health and care organisations are actively working together to strengthen system wide collaboration. A system governance and outcomes-based proposal is

value or good outcomes for public and patients.	being agreed at the Health & Wellbeing board and subsequently our system work will align accordingly.
There is a risk to clinical safety and financial sustainability through NHS services (primary, secondary and community) not being able to implement required service changes to respond to the anticipated level of demand at the scale and pace required.	The Oxfordshire Transformation Programme is under review. All service improvements are to be developed in a place based way, looking at the health and needs of the local population. The final strategy sign off and governance arrangements are awaited from the Health and Wellbeing Board.
There is a risk that OCCG will not identify and rectify healthcare quality issues in Oxfordshire resulting in sub-optimal care to patients, poor patient experience and a lack of clinical effectiveness	OCCG receives a wide range of information relating to the quality of services in Oxfordshire. Oversight of all these issues is undertaken by the Quality Committee where processes and information are reviewed regularly to ensure they are dynamic and to identify quality challenges. Current evidence that information is shared between providers & OCCG regarding Quality issues.
There is a risk that cost pressures against OCCGs allocation will lead to non-delivery of OCCG's statutory financial duty and NHSE business rules for CCGs. This will impact on future sustainability and viability and impact on providers and services	The Chief Finance Officer / Chief Operating Officer Risk Mitigation Group meets fortnightly to oversee programme. There is also monthly reporting to Chief Executive Officers on highlight and exception report basis. However there has been little impact to date of risk mitigation schemes. Internal Audit work has been commissioned to review internal controls on Continuing Health Care.
There is a risk that there will be poor patient experience and outcomes as a result of poor performance indicated by OCCG not meeting the NHS Constitutional standards.	The A&E Delivery Board is overseeing a revised urgent care plan. Clear priorities are being driven by the Emergency Care Improvement Programme (ECIP): diagnostics, OUHFT internal consultancy, demand and capacity profile. There is also a referral to treatment and cancer group that reports to an NHS England led Oversight Group. Additional capacity is being sought via Ramsay Healthcare. Delayed transfers are showing a steady fall through senior responsible officer accountability and agreed system wide targets.
There is a risk that in some areas the sustainability of primary care is challenged and this will adversely impact on the delivery	Primary care needs to change to deliver increased demand of an increase in approximately 4% per annum. It also needs

of primary, secondary and wider health system services which will impact on the care received by patients.	to proactively support rising demographic needs from long term conditions and frailty. Solutions are working to address workload (GP access hubs, triage, home visiting nurses, care navigators, social prescribing), workforce (skill mix, partner to salaried shift, portfolio careers) and infrastructure (mergers and estate). OCCG is supporting individual practices to access GP Resilience Funding as necessary. Banbury has had particular mitigating actions to address vacancies, rising costs of locums and vulnerable practices. The locality groups are working to deliver their locality place based plans with the view that these will identify how to achieve sustainability in the locality. As part of the locality plan OCCG has prioritised some recurrent funding to increase capacity in primary care.

Performance Analysis

How do we monitor performance?

The OCCG Board is responsible for discharging the duties of its constitution, which includes monitoring and scrutinising the performance of our 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 and the Quality Committee (for more information about the committees and their purpose please see page 52).

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. 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.

Performance against NHS Constitution Targets

Below outlines the NHS constitutional targets that OCCG has a duty to meet. During the past year OCCG has not met all of its constitutional targets; the following information within this report explains what remedial action has and is being taken:

Category	Indicator	Target	OCCG Achieved (2017/18)
Referral to Treatment waiting times for non-urgent consultant led treatment	Admitted and non-admitted patients to start treatment within a maximum of 18 weeks from referral	92%	**87.7%**
Cancer Waiting Times	Maximum two week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP.	93%	**95.8%**

Cancer Waiting Times	Maximum two week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)		93%	**97.1%**
	Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers		96%	**97.1%**
	Maximum 31 day wait for subsequent treatment where that treatment is surgery.		94%	**96.6%**
	Maximum 31 day wait for subsequent treatment where the treatment is an anti-cancer drug regimen.		98%	**99.7%**
	Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy.		94%	**98.7%**
	Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer		85%	**86.7%**
	Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers.		90%	**96.9%**
Diagnostic test waiting times	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral		1%	**0.9%**
A&E Waits	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	OUHFT	95%	**82.8%**
		RBFT	95%	**89.1%**
		OHFT	95%	**97.3%**
	The number of patients waiting longer than 12 hours on a trolley		0	**96**
			0	**2**

Cancelled Operations	All patients who have operations cancelled on or after the day of admission (including the day of surgery), for non-clinical reasons, to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.		0	11.9%
Mixed Sex Accommodation Breaches	Breaches of same sex accommodation		0	165
Mental Health	Dementia Diagnosis		66.7%	67.2%
Delayed Transfers of Care	Number of days delayed as % of occupied bed days	OUHFT	3.5%	10.8%
		Royal Berkshire Hospital NHS Foundation Trust	3.5%	5.0%
		OHFT	3.5%	11.4%

Information on additional performance measures is available on www.nhs.uk/mynhs

How we manage our money

OCCG's total funding for the financial year 2017/18 was £872.5m, of which £857.9m was allocated for healthcare programmes and £14.6m for running costs of OCCG. This year, the historic surplus is separately reported from the in-year position. OCCG carried forward a cumulative historic surplus of £21.129m into 2017/18 of which £1.142m was drawn down for use in the year.

In setting our financial plans at the start of the year we complied with all planning requirements and planned to breakeven in year.

As set out in the 2017/18 NHS Planning Guidance, CCGs were required to set aside a risk reserve of 0.5% at the start of the year to provide a buffer to offset wider system pressures. To comply with national requirements, NHS Oxfordshire has released this reserve to the bottom line, resulting in an additional underspend at year end of

£3.717m. The impact of this, combined with a risk reserve that NHS England (NHSE) is holding centrally, will be to increase the underspend across NHSE by about £560m, which will help offset the expected deficit position in the provider sector.

NHSE also released the Category M drugs rebate of £0.831m back to OCCG in Month 12 with the expectation that this would also improve the bottom line.

These, together with a small surplus of £0.011m, mean that OCCG achieved a surplus of £4.559m as required by NHSE. It is expected that this will be added to the historic surplus carried forward and will therefore be available for drawdown in future years.

2017/18 was the second year that OCCG had formal delegated responsibility from NHS England for GP Primary Care Commissioning and received an allocation of £92.4m in order to deliver this.

*The table b*elow outlines the budget and spend for 2017/18:

	Annual Budget £'000	Actual Month 12 £'000	Variance Month 12 £'000
Acute	418,263	426,401	8,139
Community Health	72,465	73,964	1,499
Continuing Care	63,889	66,087	2,197
Mental Health and Learning Disability	73,099	73,554	455
Delegated Co-Commissioning	92,368	92,368	(0)
Primary care	107,041	104,880	(2,160)
Other Programme	17,751	17,118	(632)
Sub Total Programme costs	**844,875**	**854,373**	**9,497**
Running costs	14,627	13,537	(1,090)
Sub Total CCG	**859,502**	**867,909**	**8,407**
Risk Reserve	5,407	0	(5,407)
1% Non recurrent reserve (50% require	3,717	0	(3,717)
0.5% Contingency reserve	3,842	0	(3,842)
Total CCG after contributions to/from r	**872,468**	**867,909**	**(4,559)**
Planned Surplus c fwd	19,989	0	(19,989)
Total	**892,457**	**867,909**	**(24,548)**

A risk share agreement was put in place for 2017/18 between OCCG and its two main providers – Oxford University Hospitals FT and Oxford Health FT. This shared the financial risks arising in the year in a pre-agreed percentage between the parties.

During 2017/18, OCCG has continued with joint commissioning and pooled budget arrangements with Oxfordshire County Council (OCC). The structure of the pools was reviewed at the start of the year and two new pools were established. The Better Care Fund (BCF) pool replaced the Older People and Physical Disability pools while the Adults with Care and Support Needs Pool replaced the Learning Disability and Mental

Health pools. The Better Care Fund of £36.7m forms part of the BCF Pool. New risk shares were agreed for each of the two new pools.

OCCG's contribution to the pooled budgets was £143m while OCC contributed £182m. There were some material movements in the reported financial position during the year. There are therefore questions as to the effectiveness of internal controls over the reporting of the in- year pooled budget positions held with the County Council and OCCG will engage Internal Audit to provide further assurance during 2018/19.

For the financial year 2018/19 we will receive a £23m increase to our funding compared to £16m in 2017/18 and £50m in 2016/17. OCCG will remain at 4.9% below "target" funding. (This is the amount a CCG would ideally receive, given the total funding that is available for distribution, to commission services for its resident population.) There remains a need for OCCG to identify and implement initiatives that improve the efficiency and value for money of our healthcare services. As a result, we have targeted a savings plan of £24m for 2018/19. Savings will be delivered in the following areas: Right Care[3], demand management, operational changes, service redesign as well as system transformation.

The key risk for OCCG moving forward into 2018/19 remains the same as it is for all NHS organisations across the country, which is to address the increasing demand for NHS services within the resources available.

Changing healthcare in Oxfordshire

Public consultation on a range of services started at the beginning of 2017. The changes proposed were:

- To make permanent the closure of the obstetric unit at the Horton General Hospital and replace with a midwife led unit.
- To consolidate services for all patients with a suspected stroke. This would mean they would be taken to a Hyper Acute Stroke Unit – for Oxfordshire this is at the John Radcliffe Hospital in Oxford. Also, to expand the early supported discharge service for stroke patients across Oxfordshire.
- To permanently close 146 acute hospital beds that had been temporarily closed and make permanent the investments in alternative community care.
- To no longer provide level 3 critical care at the Horton General Hospital, meaning all patients needing the highest level of critical care would be taken to the John Radcliffe Hospital in Oxford or another hospital in a neighbouring county if nearer. The critical care unit at the Horton would continue to provide level 2 critical care.

[3] Rightcare is a NHS programme that uses data and clinical evidence identify variation in people's clinical outcomes to help improve quality of services and treatment: www.england.nhs.uk/rightcare

- To significantly increase the planned care provided at the Horton General Hospital with an additional 90,000 outpatient, diagnostic and planned surgery appointments each year meaning fewer people travelling to Oxford.

During the consultation, 15 open public meetings took place with 1,400 people attending and 10,000 individual responses were received by OCCG. The full report of the consultation is available here.

Two additional meetings of the OCCG Board were organised. The first on 20 June was to consider the outcome of the consultation and to decide what more information would be needed to allow the Board to make a decision and the second on 10 August was to make the decisions about each proposed change. The Board agreed the above changes with the exception of the closure of beds; the Board agreed that the temporary closure of 110 beds could be made permanent but decided not to close any further hospital beds.

Two challenges were made that have delayed implementation of the decisions.

- An application for Judicial Review was made by the relevant local authorities[4] in the Banbury area, supported by the Keep the Horton General campaign as an interested party. The Judicial Review covered a number of grounds including the split of the public consultation, the adequacy of the consultation and the additional NHS England Bed Test.

  The Judicial Review Hearing was held at the High Court on 6 and 7 December 2017. Both sides presented their arguments to Justice Mostyn and the judgement was published on 21 December 2017. Justice Mostyn did not uphold any of the grounds by the Claimants and refused leave to appeal his ruling. The Interested Party has submitted an application to the Court of Appeal to determine if an appeal might be permitted.

- In August 2017, the Oxfordshire Joint Health Overview and Scrutiny Committee (Oxfordshire JHOSC) referred the OCCG proposals on a permanent change to obstetrics services to the Secretary of State for Health and Social Care. The Secretary of State received advice from the Independent Reconfiguration Panel (IRP) and wrote to the Oxfordshire JHOSC and to OCCG (on 7 March 2018); this letter and the IRP advice are available here. The letter from the Secretary of State and IRP advice covered the issues raised in the referral made by Stratford-on-Avon District Council in April 2017 as well as that from the OJHOSC. The IRP concluded that further work was required locally and their advice has been accepted by the Secretary of State.

[4] Cherwell District Council, Banbury Town Council, South Northamptonshire District Council and Stratford-on-Avon District Council

- The Secretary of State has asked OCCG and the HOSC for a joint response to describe how we will undertake this further work and we are currently in the process of writing back and describing how this will be undertaken.

There is much to be learned from our experience to date and we recognise the need to develop more involvement of local people at an early stage in the process. As a direct result of our reflection, OCCG are working on an outline plan with timescales for the further appraisal work required, including plans to involve stakeholders and the public. This proposal will then be presented to a newly formed joint HOSC (with councillor members from across our borders in the North of the county), to ensure we have incorporated all expectations for early involvement; plans will only be implemented after this stage in the process and OCCG will be reporting back on progress to the Joint HOSC at regular intervals until complete.

While this work is undertaken no permanent changes to services will be made.

Alongside this, a recent Care Quality Commission Local System Review5 has emphasised the need for much better health and social care planning together and the need for an overarching vision and strategy for health and care in Oxfordshire.

Next Steps

OCCG is taking the opportunity to plan a better way of working with partners and the public. Our recent reflections on the experience of Phase One, together with the recent Care Quality Commission Local System Review has further emphasised the need for much better health and social care planning together across the Oxfordshire system. This means not progressing with the second phase of the programme as it was originally planned. OCCG's focus over the next few months will be on enabling the health and social care system to work in a much more joined up approach across Oxfordshire, and to support our local NHS and social care organisations to work better together with and for the benefit of local people.

Working with GP practices to improve access and services in the local community

Oxfordshire Primary Care Commissioning Committee (OPCCC) is a formal committee of OCCG Board, independent of the GPs, and oversees strategy development, plans and performance issues relating to primary care.

We value the contribution of clinicians and staff in General Practice and remain committed to helping deliver transformation in Primary Care that will not only benefit patients but that will also encourage staff to come and work in Oxfordshire.

To this end, at the start of the year a primary care framework was agreed that set out the vision and approach for developing sustainable primary care for the future. This was informed by the national General Practice Forward View.

Each locality used this framework to facilitate discussions and planning for how to improve primary care services depending on local needs. These discussions included clinicians from all local practices and patient representatives. The draft plans were then discussed with the Locality Public Forums[6] and at open public meetings.

Between 3 November and 17 December 2017 the draft plans for each locality were presented and discussed at a series of public workshops around Oxfordshire, and discussed at various stakeholder meetings.

The first version of the locality plans were published on the 25 January 2018; the plans along with the engagement report for the development of the plans are available on OCCG website: http://www.oxfordshireccg.nhs.uk/about-us/locality-plans.htm

Each plan is different, but all have some consistency with some common challenges including an increase in the number of older people presenting with multiple and complex conditions; growth in housing developments; length of waiting times and concerns around primary care estates.

OCCG recognises that we must work closely with our colleagues in the District Councils as we jointly develop a strategic approach to plan for population growth and ensure there is sufficient health and care services to meet patient needs. This includes exploring potential primary care solutions for areas of greatest growth including Bicester, Didcot, Wantage and Witney.

During 2017/18 work continued to improve patient access to GP services across the county. An additional 70,000 appointments have been made available through the county's GP Access hubs. This enables patients to access GP appointments at convenient times later in the day and at the weekend. The additional capacity also releases GP time to spend on complex patients where they can make a real different to a patient's outcome. It also serves to take pressure off other parts of the system for example A&E.

The primary care visiting service, introduced last year, supports practices to respond effectively to home visit requests and to pro-actively assess and treat elderly or house-bound patients at risk of deterioration. It is also intended to reduce emergency attendances and admissions at A&E. The primary care visiting service is part of the extended general practice team and is not a separate service, so patients remain the

[6] In Oxfordshire, OCCG has six PPG Locality Forums, they are voluntary non-statutory groups, each with an elected Chair in accordance with the Forum's terms of reference, to bring the patient voice into commissioning decisions.

clinical responsibility of the GP at all times. The service will be rolled-out across the county in 2018/19.

Developing GP services and a Locality Plan in West Oxfordshire

In Witney, following an unsuccessful procurement process, Deer Park Medical Centre closed on 31 March 2017. Its patient list was dispersed to surrounding practices. In December 2016 there was a request for a Judicial Review on the decision of OCCG to close services at Deer Park Medical Centre. Whilst this was refused, , the Joint Oxfordshire Health Overview and Scrutiny Committee (JHOSC) agreed to refer the matter to the Secretary of State for Health on the grounds that the closure was a substantive change in service. As a result, the Secretary of State passed the referral to the Independent Review Panel (IRP) in March 2017. The IRP undertook an initial review and made recommendations to the SoS for local resolution these included and where supported by the SoS:

- Immediately commission a time limited project to develop a comprehensive plan for primary care and related services in Witney and its surrounds.
- Seek to produce a strategic vision for future primary care provision in line with national and regional aims.

OCCG undertook to address these recommendations through the development of the West Oxfordshire Locality Plan as described above.

Working towards a quick and efficient urgent care service and getting people out of hospital

Pressure on urgent care services across Oxfordshire including A&E and ambulance services has continued throughout 2017/18. There has been an increase in patients attending A&E of approximately 4,000 on last year and the complexity of patients has also increased.

Despite continued efforts OCCG and the OUHFT did not reach Government targets. 87.7%% (for OUHFT against a target of 92%) of people attending A&E being seen, treated and either discharged or admitted within four hours at the end of March 2018. However, this target was met within the three minor injury units across Oxfordshire provided by OHFT with 97% of patients being looked after in 4 hours. In the last quarter there was a rise in the number of people waiting more than 12 hours for an emergency admission via A&E following a decision is made to admit. This is due in the main to an increase in demand for services and some workforce issues within the hospital. Each of the 12 hour breaches are reviewed by the hospital Trust (OUHFT) and OCCG's Quality Team to understand why they have been delayed and to ensure patient care has been optimal. Whilst waiting a long time significantly affects the patient experience; the

reviews have found that the quality of care received is good and does not adversely affect the patient's outcome.

A number of initiatives have started in the past year to reduce pressure on A&Es including the provision of additional GP expertise alongside that of other clinicians in the emergency departments. GPs have worked alongside clinical colleagues in the John Radcliffe Emergency Department for several years, but since December 2017, there has been a new way of working in the department to ensure that patients attending the department get access to the right service.

The four ambulatory assessment units[7] around the county continue to assess and treat patients with complex needs. As a result, patients do not need to spend time in A&E or be admitted to an acute hospital bed for overnight stays. The new Rapid Access Care Unit (RACU) at Townlands Memorial Hospital, in Henley on Thames has been open for over a year now, has helped to reduce A&E attendances and admissions, and has been positively received by the community. Less than 3% of patients seen in the RACU needed to be transferred to acute hospital over the last 9 months. The RACU provides assessment and treatment of patients with a crisis or deterioration in their health. The service ensures patients can be assessed by a consultant and if needed receive diagnostic tests or treatments such as intravenous antibiotics on the same day to help avoid a stay in an acute hospital. The RACU has delivered a total of 1594 contacts for April to December 2017, averaging at 177 contacts per month. The RACU treated 82% of these contacts in an ambulatory context, i.e. the patients attended the unit and went home on the same day.

Delayed transfers of care[8] (DTOC) remained high throughout 2017/18 in Oxfordshire with a weekly average snapshot of 134 people delayed across community and acute hospitals. This is the same level as in 2016/17. However, the bed days lost to delays per 100,000 of population fell from 1047.5 in April 2017 to 707 by January 2018.

This reduction in "days lost to DTOC" reflects the improvement plan developed by OCCG and partners to the *Better Care Fund* plan. There has been strong partnership working that has proved effective in managing the length of time that many patients are delayed during 2017-18:

- OCCG has reviewed continuing healthcare assessment processes for people in hospital: by February the number of people assessed in hospital had reduced to 10% of the total as more people were moved into nursing homes for their assessment

[7] The ambulatory assessment units are based at the John Radcliffe Hospital, Horton General and Abingdon and Witney Community Hospitals. They also assess and treat patients on a same-day basis so they do not have to be admitted to a hospital bed, which is better for patients.

[8] Delayed Transfers of Care (DTOC): this may be experienced by a hospital patient who is ready to leave hospital but is prevented from doing so because, for example, there is no one at home to look after them or there are no spaces available in a care home

- Local teams in OHFT and OCC have worked to reduce long waiters in community hospitals, particularly where there are complex issues relating to housing or other long-term needs, and/or where the patient is funding his or her own onward care
- A *trusted assessor* model has been adopted by Oxford university Hospitals NHS FT and Oxford Health to reduce bureaucracy and duplicate assessment for people moving to longer-term rehabilitation.

The key obstacle to a sustained and long-term improvement in the DTOC rate is the capacity of the domiciliary care market, and the availability of long-term nursing home placements especially for more complex patients. OCCG is working with OCC to create the capacity and capability that will ensure flow out of hospital.

OCCG has worked with partners to develop an action plan in response to the Care Quality Commission's report published in February 2018. Integral to the Plan is an improvement plan which will be delivered by the Accident & Emergency Delivery Board to

- Model demand and capacity to improve our ability to escalate in response to operational demands, and also to deliver, in the longer term a reduction in people delayed in our system
- Reduce attendances at and admissions to hospital by improving the response of community services
- Improving the flow of patients through the emergency department when they need to be admitted
- Implementing a *Home First* approach to reduce stranded patients and other people delayed in hospital beds.

Implementation of this plan will underpin a planned reduction of people delayed in hospital in 2017/18.

Ambulance response times also remain challenging across the county, although South Central Ambulance NHS Foundation Trust (SCAS) is one of the best performing ambulance trusts in England. The main initiative to improve response times being undertaken by SCAS is the National Ambulance Response Programme (NARP), which aims to support ambulance services to:

- Use a new pre-triage set of questions to identify those patients in need of the fastest response at the earliest opportunity
- Dispatch of the most clinically appropriate vehicle to each patient within a timeframe that meets their clinical need
- A new evidence-based set of clinical codes that better describe the patient's presenting condition and response/resource requirement

Getting the right treatment

During 2017/18 OCCG sought to improve planned care services for the Oxfordshire population. The programme included a number of approaches to reduce unnecessary appointments and work to support the local hospitals with capacity problems.

OOCG has worked closely with 15 GP practices in the county to reduce referrals and enable patients to be treated locally in the GP practice, which has helped to reduce referrals to other services by 3% within those practices. We have expanded the use of email communication between GPs and consultants, with 52 actively monitored advice lines saving over 5,000 unnecessary appointments in 2017/18. OOCG has also worked closely with the highest volume specialties; Gynaecology, ENT, Ophthalmology, Orthopaedics, Gastroenterology, Neurology, Cardiology, Dermatology and Urology to jointly address the demand and capacity issues that they face. This joint work has resulted in identifying follow up appointments that could be delivered in alternative ways, publishing guidance for referring GPs, and supporting specialties with additional work where required to meet demand.

OCCG has worked closely with the cardiology service at the John Radcliffe Hospital to deliver a pilot for an integrated community service. The service offers appointments to patients with heart problems in a number of community locations. GPs were recruited and given training in Cardiology to deliver these services. The results have been good with more patients than expected being seen out of hospital, savings have been made and the feedback from patients has been very positive. Given its success the service will be rolled out across the whole county.

Another pilot scheme developed over the past year is the GP-specialist led headache clinic in the community. A review will be conducted in 2018/19 to establish whether to commission the service going forward. Early results indicate that this is improving outpatient capacity in Neurology at OUHFT, is well received by patients, and on track to make a saving of over £50,000 in its first 12 months.

OCCG, the Oxford Eye Hospital and Primary Eyecare Oxford, the Minor Eye Conditions Service provider, have worked together to change the service model and pathways of care for those with urgent eye conditions. We have been able to better support patients in accessing pharmacies to resolve their minor ailments, and to self-manage front of eye disease. This has resulted in a 50% reduction in activity through the Minor Eye Conditions Service and over 1,000 fewer visits to Eye Casualty in 2017/18.

Referral to treatment times[9], a NHS Constitution standard, continues to be challenging for Oxfordshire. The gynaecology services in particular have had problems getting all patients seen on time, and has consequently had a large number of patients waiting longer than 52 weeks. OCCG has invested some additional funding to ensure these

[9] This standard says that 92% of patients referred ,usually by their GP, to a consultant, must be seen by the service they are referred to and receive any resulting treatment offered as a result within 18 weeks, in England.

women are treated in the last part of this year (2017/18) and the first 2-3 months of next financial year (2018/19). Currently there are 115 waiting (in February 2018) and there is a plan to reduce this by 50% by March 2019.

OCCG has been working hard to implement the NHS Cancer Strategy locally. A new Suspected CANcer pathway (SCAN) has been implemented which is part of the Accelerate, Coordinate; Evaluate (ACE) Wave 2 national programme and community diagnostic services now include the 2 week wait pathway. Faecal immunochemical testing (FiT) for bowel cancer screening has been implemented across the county and many pathways have been reviewed to enable upfront diagnostic tests to be conducted (Lung – early CT and Prostate – early MRI).

Work has also begun, in conjunction with NHS England, Cancer Research UK and Macmillan Cancer Support, on improving quality in diagnosing cancer using specially designed IT toolkits, to enable practices to identify the patient cohorts that need a specific focus in terms of care for screening, cancer care and living with and beyond cancer (LWBC). Significant improvement has been made in meeting the eight waiting time standards for cancer across Oxfordshire.

In September 2017 the new provider, Healthshare, took over the provision of musculoskeletal services (MSK) in the county following a significant programme to redesign diagnoses and treatment. The transition was a busy time, with MSK being such an area of high demand the handover totalled in the region of 8700 patients who either required care to continue or were awaiting care. Whilst there were some issues with communication and telephone access being difficult, the service is going well. For routine physiotherapy wait times have dropped from up to 26 weeks in some places to around the 10 to 12 weeks. The new service has received 40,387 referrals up to the end of February 2018.

Improving mental health services

During 2017/18 OCCG has continued to focus on *parity of esteem*, the principle by which mental health must be given equal priority to physical health. We have also been looking more broadly at how OCCG meets the mental health needs of the whole population in primary care, community and acute settings.

We are also committed to delivery of the national 'Mental Health Five Year Forward View' and the associated improvements in access and waiting times. This year we have established a multi-agency delivery group to work together in an integrated way as system partners to consider local priorities and delivery plans.

Oxfordshire's performance in respect of national indicators has been strong as outlined in the table overleaf:

Indicator	Target Yr 2 2017/18	Performance Q4
Increase the number of people with mild to moderate mental illness accessing psychological therapies	17%	17.4%
Waiting time for psychological therapy for mild to moderate depression & anxiety – 6 weeks	75%	98.7%
Waiting time for psychological therapy for mild to moderate depression & anxiety – 18 weeks	95%	99.9%
Early Intervention in Psychosis (EIP) services - 50% of people treated with a NICE-approved care package within two weeks of referral.	55%	84%
Care Programme Approach (CPA): Proportion of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care.	95%	97%

Since 2014/15 OCCG has been engaged in a programme of commissioning services to deliver better mental health. Working with users, carers and clinicians we have developed contracts which have focussed on the integration of medical, social and voluntary sector services that will deliver better outcomes for people with poor mental health. These contracts have been designed to meet most of the requirements in the *Mental Health Five Year Forward View*:

- We have commissioned OHFT and its partners to deliver a new model of care for children and young people through an outcomes based contract that will deliver transformational change by 2022. The contract is a key part of the implementation of our *Local Transformation Plan*. See page 27.
- We have similarly commissioned OHFT in two outcome based contracts, one for adults with severe mental illness, delivered by the *Oxfordshire Mental Health Partnership*(OMHP)[10] and one for people with mild to moderate depression and anxiety, delivered by *TalkingSpacePlus*[11] which run until 2020 and 2021 respectively. Both contracts incentivise providers to focus on recovery, resilience and wellbeing for people, and on improving access and service quality.

The outcomes based contract for severe mental illness is delivering improvements as outlined overleaf:

[10] http://omhp.org.uk/ A partnership of Oxford Health NHS Foundation Trust, Oxfordshire Mind, Response, Restore, Connections and Elmore.

[11] https://www.oxfordhealth.nhs.uk/talkingspaceplus/ A partnership of Oxford Health NHS Foundation Trust, Oxfordshire Mind and Principal Medical Ltd.

Indicator	Target 2017/18	Performance Q4
Percentage of all referrals to adult mental health teams that are categorised as crisis/emergency where the patient (and carer where applicable) and the referring GP are contacted within 2 hours.	95%	79% (22/28)
% of service users who have been discharged from Oxford Health Foundation Trust (OHFT) and are not readmitted to hospital at 28 days after discharge	93%	91%
% of service users who have been discharged from OHFT and are not readmitted to hospital at 90 days after discharge	88%	88%
Increase the proportion of people with severe mental illness in employment	18%	21%
Increase the proportion of service users in paid employment, undertaking a structured education or training programme or undertaking structured voluntary activity	60%	61%
Increase the proportion of people with severe mental illness in settled accommodation	80%	95%
Proportion of identified carers who are satisfied with the care and support received by the person s/he cares for	80%	92%
Proportion of reduction in the prevalence of smoking amongst the service user population under the care of the Oxfordshire Mental Health Partnership	42.5%	38%

In 2016/17 TalkingSpacePlus provided mental health information and advice for more than 10,000 people, and saw more than 11,000 people to support their mental wellbeing and depression and/or anxiety. We have extended the service this year to improve access to mental health support for those people with physical health conditions, in particular diabetes, chronic obstructive pulmonary disorder, asthma and cardiac problems.

The OMHP supports around 3,500 people in the community at any one time. The OMHP provides a complete recovery package to support someone on their journey, for example the *Recovery College*[12] provides opportunities for people using services to share learning and identify and develop their own resources to help them manage their own health.

OCCG is working with OMHP and Oxford University Hospitals NHSFT to develop a better range of services to prevent hospital admission or inappropriate attendances at A&E. We have added a further local health-based place of safety to avoid the use of police cells for people in crisis, and are working towards a mental health single point of access for people whenever they need help or touch emergency services.

During 2017/18 OCCG primary care localities have been looking at the mental health needs of the communities they serve. Some people who do not wish to engage with specialist mental health services do visit primary care. Other people don't quite meet the threshold for specialist services but do need help. In 2018/19 we will be developing an enhanced and more flexible mental health service closer to home with a focus on

[12] http://oxfordshirerecoverycollege.org.uk/

increasing mental wellbeing to improve patient outcomes. The service will be voluntary sector led and co-located within primary care and tested throughout 2018/19.

Another focus this year has been improving access to mental health support for those people with physical health conditions, in particular diabetes, chronic obstructive pulmonary disorder, asthma and cardiac problems. People with one long term physical health conditions are two to three times more likely to suffer from depression or anxiety, and people with more than one long term condition are 7 times more likely.

TalkingSpacePlus has been establishing itself within community clinics and working with specialist teams and GP practices to make sure taking account of people's mental health needs becomes the norm within their long term condition care plans. This part of the service has worked with over 900 people with long term conditions and is planned to work with over 2000 next year.

Improving Care for people with learning disabilities

On 1 July 2017 OHFT successfully took over the provision of specialist health services for people with learning disabilities from Southern Health NHS Foundation Trust. The transition of services was overseen by OCCG, working alongside service users, family carers and the wider learning disability community in Oxfordshire.

OCCG has been working in partnership with service users, family carers, the local authority and health providers to deliver Transforming Care in Oxfordshire. This is the local programme to deliver the national strategy for people with learning disabilities and / or autism who have behaviour which challenges, including those with a mental health condition. The plan is focused on improving health and care services to enable people to live more independent lives in the community and reduce admissions to hospital.

The Oxfordshire Transforming Care Partnership Board is now co-chaired by a family carer and a person with a learning disability. This further consolidates the co-production approach that OCCG and partners have taken to the development and delivery of the programme.

A key element of the Transforming Care Programme has been the review of the urgent care pathway for people with learning disabilities. Part of this work has meant that the existing adult OHFT Intensive Support Team, which provides short term support for people in crisis, has been developed and has extended its remit to work with children and young people from 1 April 2018.

OHFT has also begun developing a Trust-wide, all age autism strategy. This will cover learning disability, mental health and community health services and will be implemented in the second half of 2018/19.

Over the past year a focus of the primary care Local Incentive Scheme (OCCG's local scheme to incentivise service developments and improvements in primary care) has

been on learning disability, mental health, autism and dementia. In relation to learning disabilities, the scheme has incentivised primary care staff to engage in training to improve performance in the delivery of annual health checks.

The scheme will continue to focus on learning disabilities in 2018/19, incentivising GP practices to implement changes to improve primary care services for people with a learning disability and delivering annual health checks to 75% of patients aged 14 and above.

Developing services for children and young people

A review of the Children's Clinical Decision Unit (CDU) located at the John Radcliffe Hospital (JR) was undertaken to understand the current provision of ambulatory care[13] for children across Oxfordshire. The review found that the unit formed an integral part of the urgent care pathway for children and took many referrals from A&E and directly from GPs. The review also found that improved communication and coordination of the transfer of children from acute care to community provision had the potential to reduce the amount of times children and their families had to return to the JR, thus improving patient experience, and the cost to the system as a whole. As a result of the review, a pilot Winter Pressures Clinic was set up and run by OHFT's Children's Community Nurses to improve the flow of patients to the community provision. The pilot was launched in December 2017 and will run until March 2018 at which point it will be fully evaluated by OCCG.

The new Children and Adolescent Mental Health Service (CAMHS) contract commenced in May 2017 and is now in the early stages of mobilisation. As stated in last year's report the new contract aims to improve the quality and access to CAMHS in Oxfordshire. In particular it will concentrate on reducing waiting times and will have an emphasis on prevention, self -help and early intervention. The service has been completely redesigned following an extensive review and the advent of the Future in Mind publication.

The contract is delivered in partnership with a number of local charities who also deliver bespoke support to young people who find it difficult to engage with traditional services. All work with young people up to the age of 25 and will have an important role in the transitioning of those young people who still need support, but for whom adult mental health services are not appropriate. The key elements of the new model are to:

- Offer information, advice and consultation to young people, their families and professional
- Single point of access and a service without tiers
- Self-referrals for young people and families

[13] Ambulatory care or outpatient care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services.

- Support to schools and colleges through direct work , training, information, advice and consultation to build capacity in the wider workforce
- Outcome focused encouraging young people to set their own goals
- Use of technology including building a new website with self-help tools to encourage self-care
- Work with the Third Sector to deliver the contract and benefit from their unique capabilities
- Work in partnership with Children's Services, Education, Primary Care and Public Health Services such as School Health Nurses
- Deliver care in local community to avoid unnecessary hospital admissions and speedy access to inpatient care when needed that is close to home

Managing medicines better

In 2017/18, OCCG spent £82.5 million on medicines prescribed by family doctors for the population in Oxfordshire, 9.5% of our overall budget. As in previous years, there were significant cost pressures on prescribing but OCCG's Medicines Optimisation Team continued to work closely with the GP practices and other clinicians to promote good quality, cost-effective prescribing across the county.

There was a change to the usual format of the Prescribing Incentive Scheme (PIS) but practices continued to work hard to meet their targets identified with support from the Medicines Optimisation Team. Progress was monitored monthly and data made available to practices via the Prescribing Dashboard on OCCG's website. To support appropriate prescribing, practices continued to use the ScriptSwitch software tool providing savings for the year of £1.56 million.

The OCCG prescribing formulary was made available online to all practices in 2017. This uses a traffic light system to guide where clinical and prescribing responsibilities lie in regard to the initiation and maintenance of prescribing. 'Black' drugs are not normally recommended for prescribing due to lack of evidence or because there is a more cost effective alternative, 'red' drugs should only be prescribed by a specialist and 'specials' are usually very expensive products and a suitable, cheaper alternative may be available. The Medicines Optimisation Team works with practices to minimise spend in these areas.

Work was done across OCCG to encourage patients to self-care and buy medicines over the counter (OTC), where appropriate. Resources were made available to practices to aid implementation of this policy and savings for the year on this were calculated as £191k.

The team seconded a dietitian to support its work around the appropriate use of oral nutrition. Audits were done in practices to review prescribing of infant formulas, sip feeds and gluten free products as well as offer advice to prescribers releasing savings of £121k for the year.

The Minor Ailment Scheme (MAS) continued to be provided at some pharmacies in the county resulting in a reduction in waiting times and GP workload. It was decided that this should be rolled out to more practices for the start of 2018/19. In addition, the small pilot to provide advice and treatment to appropriate patients with uncomplicated urinary tract infections (UTIs) using a Patient Group Direction (PGD) was extended across the whole county in November 2017. The aim of the service is to reduce pressure on GP practices and Out of Hours services by redirecting some patients to a pharmacy; this gives greater patient access to alternative services and care.

Over prescribing of antibiotics is of worldwide concern with the increasing evidence of drug-resistance in bacteria. Significant work has been done in Oxfordshire to ensure that prescribing of antimicrobials is appropriate. Allowing for different demographics, prescribing of antibiotics in OCCG is considerably lower than the national average although the prescribing of high risk antibiotics is above the national average. However, having a low baseline of prescribing of antibiotics generally makes it harder to achieve further reductions.

While the team worked hard with practices to encourage cost-effective prescribing, there were several unavoidable cost pressures. Of particular note were the national cost pressures from shortages of certain medicines. No Cheaper Stock Obtainable (NCSO) price concessions are granted on a monthly basis by the Department of Health and Social Care in order to ensure community pharmacies receive sufficient reimbursement for the medication they dispense. NCSO concessions are, almost exclusively, applied to generic drugs which have become difficult to source and, as a result, have become more expensive to purchase. This creates a risk for OCCG because there is minimal insight as to which products are unavailable at the Department of Health and Social Care's listed price and no knowledge of any likely increase in price. While NCSO concessions have always existed, we saw a much larger number granted during 2017/18 which resulted in significant additional cost to OCCG.

Improving Quality

Improving the quality of healthcare provided to people in Oxfordshire is at the heart of OCCG's work. To enable OCCG to do this systematically feedback is collected from members of the public about their experiences of healthcare through a range of methods including compliments and complaints; patient experience surveys and provider performance data. Oversight of quality is undertaken at each OCCG Board meeting in public and the Quality Committee, a committee of the Board is chaired by the Lay Member for Public Participation and Involvement (PPI).

OOCG provides a feedback mechanism for GPs to share information with us on the services commissioned by OCCG. Datix, OCCG's online quality reporting system, continues to be an effective tool for GPs and is helping to improve the quality of services. It allows GP feedback to be captured across the 70 GP practices, enabling the

identification of the causes of commonly occurring incidents and trends. OOCG works with providers to prevent them happening again, and to identify problems early to find solutions and improve care for patients.

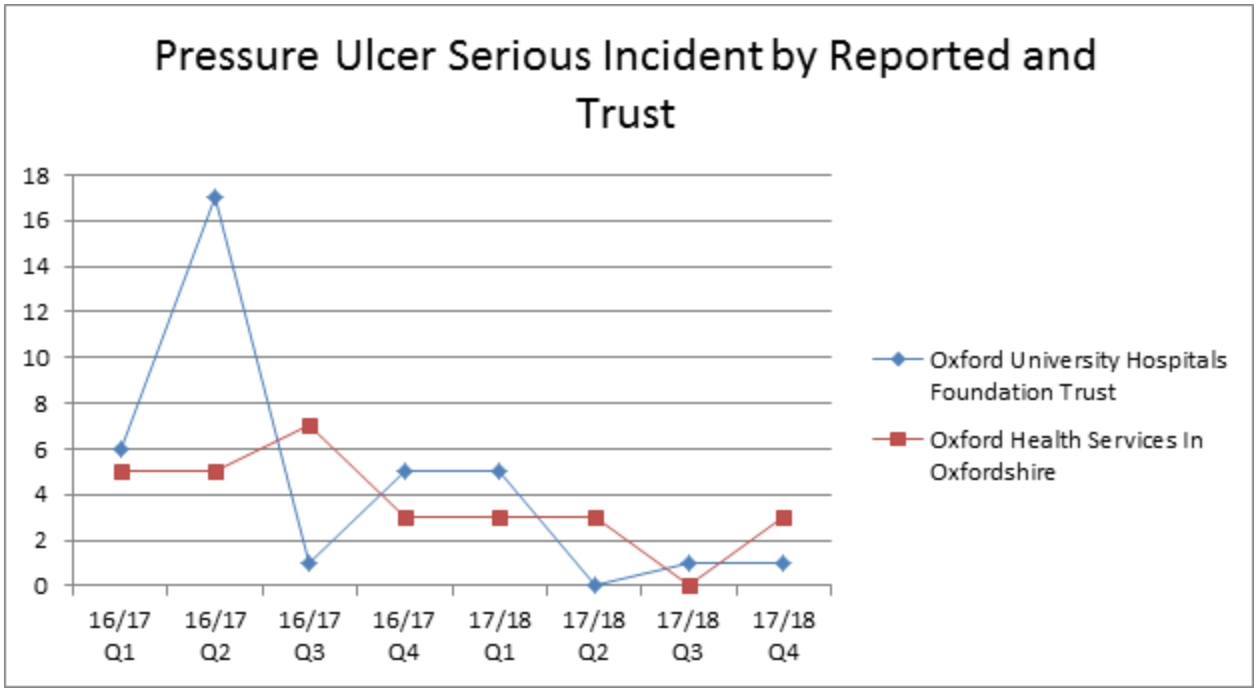
Between April 2017 and 31 March 2018, 2,050 pieces of feedback were reported via Datix. This information is used with information from serious incidents, patient experience and performance data to identify where services and care could be improved. OCCG addresses issues identified and regular progress reports are shared with GPs, providers and the Local Medical Committee (LMC) to show that change is taking place as a result of the feedback received, or that we are applying pressure through the service contract where the change is too slow.

OCCG has received 34 formal complaints during 2017/18. One complaint was referred to the Ombudsman and required no further action from OCCG.

When a serious incident (SI) occurs within one of the contracted providers, they are required to report it to the OCCG. OCCG ensures that an investigation is undertaken by the provider that meets national and contractual timescales. The investigation is reviewed by OCCG to ensure that all lessons are learned, and a plan is put in place to prevent reoccurrence. There were 145 serious incidents reported to OCCG between 1 April 2017 and 31 March 2018. As an organisation, OCCG has not declared any serious incidents. Information on how these incidents are disclosed and managed is available in OCCG's Governance Statement on page 50.

There was a reduction of 78 serious incidents reported this year compared to last. The majority of this reduction can be explained by the success of the pressure ulcer prevention work being undertaken by OHFT and OUFT. The project has used personalised care plans, 'react to red', psychological support, quick time learning and capacity tools to reduce the incidence of pressure damage. OUHFT has also reported a decrease in hospital acquired pressure ulcers. The key focus has been around awareness of equipment related pressure ulcer damage and implementing high impact staff training.

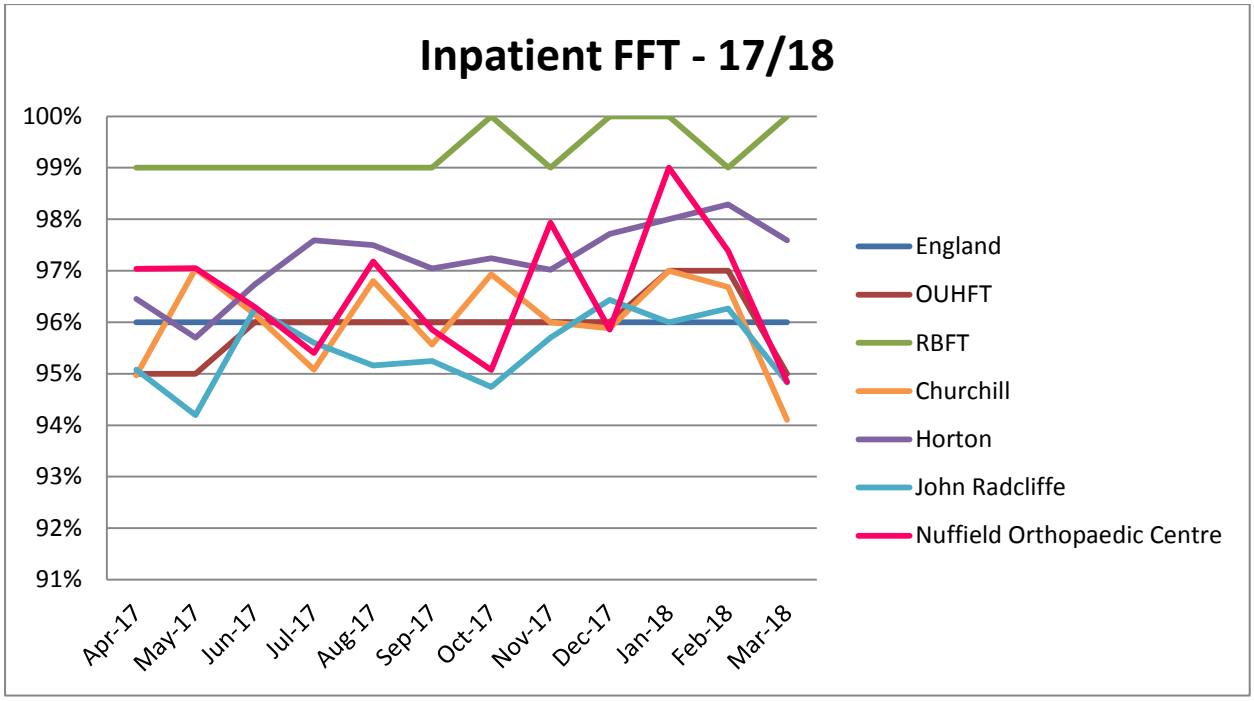
The graph overleaf shows all pressure ulcers reported between 1 April 2016 and 31 March 2018.

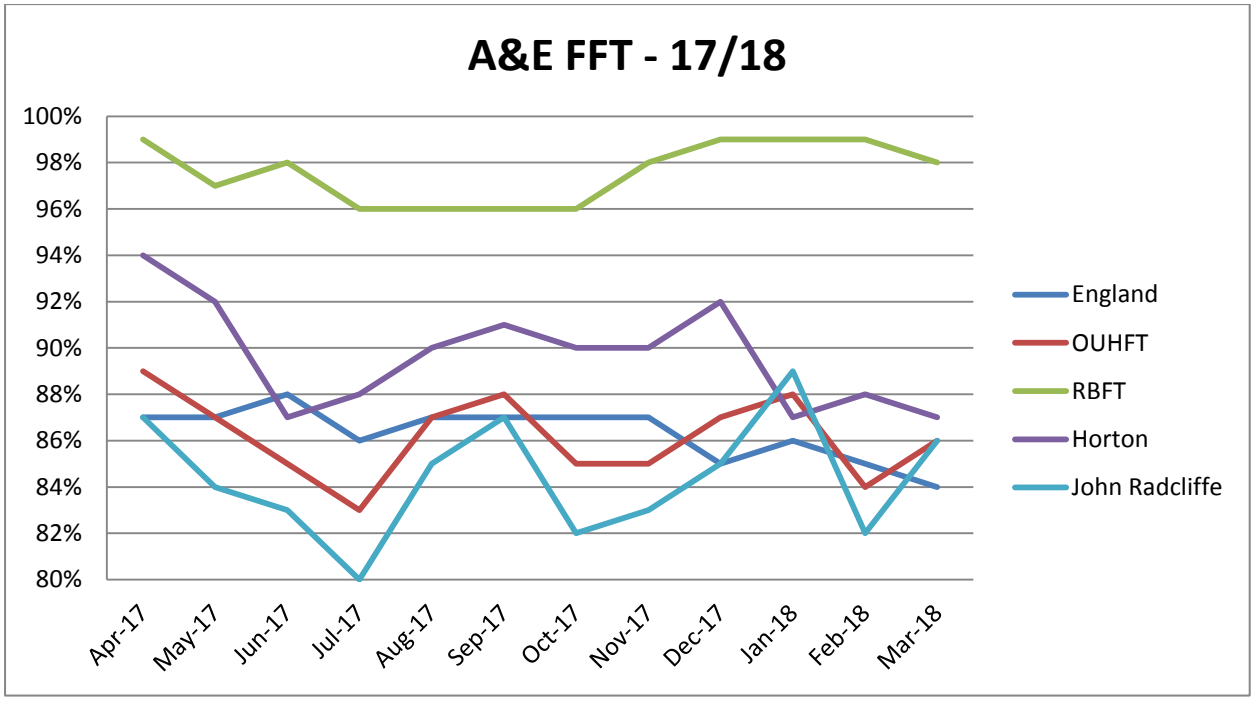


Of the 70 GP practices in Oxfordshire four have been rated as outstanding by the CQC, 65 are rated good and one requires improvement. Last year 10 practices required improvement. No practices are rated inadequate. OCCG has been successful in working with practices to support them to make required improvements.

OUHFT is rated good overall, however, the John Radcliffe Hospital is rated as requires improvement. OHFT is also rated as good overall. The independent hospitals are all rated good by the CQC. OCCG monitors the progress of all providers through regular contract meetings.

The charts below show the high level of patient satisfaction with local services gleaned from the Friends and Family Test (FFT) for A&E and inpatients. FFT is a nationally mandated test where patients are asked, on leaving a service, how likely they would be to recommend the ward or service to a friend or a member of their family with the same need. The results are presented as a percentage who responded either ‘extremely likely’ or ‘likely’ to recommend.





OCCG follows the Parliamentary and Health Services Ombudsman's Principles for Remedy in complaint handling. This means that OCCG supports patients and the public to make complaints, and seek to resolve issues whether or not they are submitted as formal complaints. When appropriate OCCG facilitates a meeting between the complainant and the organisations involved so that resolution can be reached. Where changes are made as a result of a complaint the complainant is informed of the changes. Many of the complaints managed apply to a number of organisations. In these cases an 'end to end' review of the complaint is conducted. This produces a thorough

understanding of the issues and enables the agencies to work together to make improvement and prevent recurrence.

Reducing Health Inequalities

The Joint Strategic Needs Assessment (JSNA) contains information about people in Oxfordshire, which elaborates their health and wellbeing needs. OCCG and Oxfordshire County Council use the JSNA to work together to understand the future health, care and wellbeing needs of their community. Regular joint meetings are also now scheduled between Public Health and OCCG. This enables a deeper focus on specific data sets to gain a better understanding of potential unmet needs.

In OCCG's five year Strategy 2014/15 – 2018/19, the OCCG is committed to working with statutory and voluntary sector partners to promote equality and tackle health inequalities in Oxfordshire.

Following publication of the Health Inequalities Commission report in December 2016, a multi-agency Implementation Group was set up. This group is tasked with ensuring that the report recommendations are taken forward. A stakeholder workshop was held in April 2017 to review some of the actions. A gap analysis and implementation of the recommended actions is an ongoing process. There has been a focus on the recommendation to realise the potential for social prescribing, which has led to the development of plans and partnerships to take this forward.

Another recommendation was to create an Innovation Fund which could be used to initiate community based projects. The Growth Board secured £12K funding from all the Local Authorities and OCCG has matched funded this. Oxfordshire Community Foundation has agreed to hold the funding and the Implementation Group is working with the charity to set the fund criteria.

OCCG has a designated Equality and Access team which supports commissioners to engage with seldom heard/diverse groups. The team also conducts surveys to gather patients' views on services.

OCCG and local health services have supported the Syrian Vulnerable Persons Resettlement (VPR) Programme led by the Home Office since 2015. The programme has since developed and now resettles all those Refugees fleeing the conflict in Syria, regardless of their nationality. On 21 April 2016, the Vulnerable Children's Resettlement Scheme (VCRS) was announced. This scheme has been specifically tailored to resettle vulnerable and refugee children at risk (and their families). During 2017/18 85 refugees (20 families) have been welcomed into Oxfordshire. Some refugees have arrived from Sudan and Iraq as part of the Vulnerable Children's Resettlement Scheme. Support provided though the programme helps families settle and integrate into life in the UK. In Oxfordshire the resettlement process is led by District Councils, who coordinate partner

organisations from the statutory and voluntary sector. GP practices have been incredibly supportive of the schemes and we have been able to identify a GP practice for families before they arrive to ensure that their health needs are met soon after arrival.

The CCG also supports a programme of work for unaccompanied asylum seeker children. These children are primarily supported by OHFT's Phoenix Team where each individual child has a comprehensive health assessment and subsequent health action plan. The team oversees the coordination of assessments and quality as well as ensuring prompt access to health services where needed. In addition a new post has been created to provide additional mental health support (CAMHS) in the Young People's Housing Pathway where some of the older Unaccompanied Asylum Seekers are often housed. The OCCG and CAMHS are working in partnership with Oxfordshire County Council and housing providers to ensure timely access to mental health support for this vulnerable group of children.

Other work focusing on vulnerable people / groups includes:

- Learning Disabilities and Autism
    - Vulnerable Adult Mortality Review
    - Transforming Care for People with Learning Disabilities and/or Autism
- Looked After Children Services Developments
- The Oxfordshire Transformation Programme to improve the health of the population, reduce inequalities and deliver services which are high quality, cost effective and sustainable.
- Engagement with patients regarding the closure of Deer Park Surgery, to ensure that all patients are still able to access a GP.
- Development of the Locality Plans across the county to ensure inclusion of specific actions to address significant health inequalities.

Work is ongoing in the multi-agency health partnerships in the Oxfordshire localities, through action plans which help to address local health issues. In Banbury, the Brighter Futures in Banbury regeneration programme has had a refresh through a series of stakeholder workshops and a revised action plan.

Sustainable development

OCCG submitted the Sustainable Development Unit (SDU)'s new Sustainable Development Assessment tool (SDAT) with a 65% overall score in 2018. This work was done in collaboration with local charity The Centre for Sustainable Healthcare.

Endorsement of Oxfordshire OCCG's Sustainability Work:

The Centre for Sustainable Healthcare (CSH) has worked with Oxfordshire CCG since 2015 to engage staff with sustainability and to support them to undertake various projects. During this time the team at OCCG has moved to a much more sophisticated understanding of their own environmental impact and of the levers which will enable them to improve their carbon emissions and those of their commissioned partner organisations.

In 2015 CSH estimated and analysed the OCCG's carbon footprint for the first time. In collaboration with OCCG's steering group the results of the report were incorporated into the organisation's Sustainable Development Management Plan for 2016.

In 2016 CSH and Oxfordshire CCG in partnership with the Local Pharmaceutical Committee worked together on an inhaler recycling project expanding inhaler recycling facilities within Oxfordshire's pharmacies and thereby reducing the environmental impact of inhaler waste.

At the same time CSH supported OCCG in embedding sustainable healthcare in OCCG's working practices through 2 workshops and a review of their procurement policy.

CSH has supported OCCG in successfully submitting their Corporate Citizenship Assessment report in 2016 and the new Sustainable Development Assessment Tool in 2018.

Examples of some OCCG projects that promote environmental, social and economic sustainability for Oxfordshire residents:

- Promoting inhaler recycling and recovery in Oxfordshire: Global healthcare company GSK 'Complete the Cycle' scheme continues to run in Oxfordshire and 56 Oxfordshire pharmacies are currently participating in this scheme. Find the nearest participating pharmacy here: https://pharmacyfinder.completethecycle.eu/index.html
- Social Prescribing is now part of most OCCGs Locality Plans. Additionally, two funding bids have been submitted to NHS England to further develop Social Prescribing in Oxford, Cherwell and West Oxfordshire. Social Prescribing aims to improve people's social connectedness, improve health outcomes, especially in areas of deprivation and reduce demand on primary care services.
- Opportunities for using surplus food are maximised: surplus food was used for a 'Big Lunch' event in the Leys last September. The Big Lunch initiative aims to reach out and involve people who might be lonely or isolated. The Six steps to a healthier you leaflet was launched. Church leaders who undertake welcome visits to new residents in Kingsmere, Elmsbrook and Graven Hill have agreed to hand out the leaflet on their visits. Copies have been handed out at the Big Lunch and Bicester Bike Day.

- Governance: Sustainability along with Equality Analysis is part of all business plan screening and decision making via OCCG Programme Management Office.

Equality and Diversity

Under the Equality Act 2010 and the Public Sector Equality Duty (PSED), the NHS and other statutory bodies must show 'due regard' to eliminating discrimination. OCCG has applied this 'due regard' principle in the form of an equality analysis. This process helps us make fair, robust and transparent decisions based on understanding of the needs and rights of the population, and to ensure our priorities demonstrate meaningful and sustainable outcomes for the nine 'protected groups'- age, disability, race, sex, sexual orientation, religion or belief, gender reassignment, marriage and civil partnership and pregnancy or maternity. Equality analysis is a key process used by OCCG to evidence 'due regard' of consideration of the nine protected groups in our planning and decisions. Copies of completed Equality Analyses can be found on OCCG's website.

During 2017, OCCG continued to build on the excellent work already undertaken and made good progress with the actions arising from the work in implementing the Equality Delivery System (EDS2) and Workforce Race Equality Standard (WRES) where OCCG was able to identify key constraints and gaps. OCCG engaged the patient Equality Reference Group (ERG) which monitors the progress against the action plan, which was developed following the 2016 EDS2 scoring exercise and particularly focuses on the areas where the OCCG is still 'developing'. OCCG undertook an additional focus on one protected characteristic group: learning disability.

The staff Equality and Diversity Working Group implements actions and objectives which have been developed in partnership with the patient ERG and are then agreed by the Strategic Group. The Working Group has representation from staff across all OCCG directorates and ensures that equality and diversity is embedded in all business planning, processes and commissioning activities. The Working Group ensures that governance procedures are followed in OCCG so that decisions are equitable and any potential disadvantages are mitigated as part of a defined action plan.

From 1 August 2016 all organisations which provide NHS care and publicly funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific approach to identifying, recording and meeting the information and communication support needs of patients, service users and carers with a disability, impairment or sensory loss. OCCG is working with providers to ensure they remain compliant with the Accessible Information Standard, as required by the NHS National Standards Contract for clinical services.

In 2017, OCCG also designed and developed a new public facing website solution to improve accessibility, content, design and usability for all users. Patient representatives

from the Equality Reference Group contributed to the development and testing of the new website. The website is designed to meet the NHS Accessible Information Standards, all level AA and most AAA Web Content Accessibility Guidelines (WCAG). This includes features such as the ability to translate page content into another language, or change text colours and sizes at the click of a button.

As part of the suite of statutory and mandatory training all OCCG employees are required to undertake Equality, Diversity and Human Rights training every three years. This online training course is provided through Skills for Health and is tailormade for healthcare staff. 85% of OCCG staff have completed this training and steps are being taken to ensure this increases. Additionally, further Equality Analysis training was provided to new staff members. All training ensures that staff have the knowledge, awareness and understanding of the needs of patients from the nine protected characteristic groups, so that they have equality of access to services and treatment.

Health and wellbeing strategy

Oxfordshire Health and Wellbeing Board (HAWB) 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 was set up to ensure that we work together to improve everyone's health and wellbeing, especially those people who have health problems or are in difficult circumstances.

The board provides strategic leadership for health and wellbeing across the county. Dr Kiren Collison, OCCG's Clinical Chair is the Vice Chairman of the Health and Wellbeing Board which is chaired by the Leader of the council. At the beginning of 2018 the HAWB agreed to a review of its functions, structure and governance. The Chair and Vice-Chair undertook an extensive process of review through interviewing key stakeholders and inviting written views. The meetings were informal and the views expressed non-attributable. The outcome was presented to the Health and Wellbeing Board at their meeting on 22 March and is available on their website here.

Once the review is complete and a new HAWB and supporting governance structure is in place the HAWB will review its strategy for Oxfordshire. The revised strategy will set out the Board's ambition for the years ahead which will help to drive improvement on the issues that need a partnership approach in the county. The strategy will be reflected in OCCG's own strategy and priorities.

The current Health and wellbeing Strategy is available here.

Engaging people and communities

OCCG is committed to putting the views of local people at the heart of the NHS and making sure that they are included as equal partners in the planning of local services.

OCCG aims to seek patient feedback and experience from a wide range of sources to build on what is reported to work well, and change services where negative feedback is received as shown on page 30.

Communicating and engaging with the local population is key to achieving OCCG's vision. OCCG is committed to putting patients first and applying the principle of *'No decision about me without me'* in our commissioning approach. To ensure this happens there is a communications and engagement strategy, which sets out the approach to communicating and engaging with people in Oxfordshire. It is based on the principle of open and continuous communication with patients, the public, OCCG members, staff and key stakeholders. It also acknowledges OCCG's statutory responsibilities and the NHS commitment to involve patients in how health services are planned and managed.

For each project or stream of work OCCG evaluates the requirement for engagement and consultation and maps the type and methods that it might use. This process could involve some if not all of the following steps: stakeholder analysis (in partnership with our health inequalities team); communications and engagement plans; development of a patient advisory group; patient representation on a clinical advisory group; involvement activities, which may include public meetings, workshops, surveys and focus groups or in some cases formal consultation and an equality impact assessment.

A major piece of work undertaken in the past year was the Phase One of the consultation for the Oxfordshire Transformation Programme which took place from January to April 2017 as outlined on page 16.

Throughout the summer of 2017, GPs met with members of their patient participation group to talk about how they currently work, what challenges they regularly face and how they could work better for the benefit of their patients. A period of public engagement was undertaken between 3 November and 3 December 2017. The key priorities and proposals for each locality were presented and discussed at a series of public workshops around Oxfordshire, and discussed at various stakeholder meetings. OCCG has also been talking to Patient Participation Groups to find out more about the patient experience, listening to what patients feel is important and their ideas for change. These initial plans have now been published.

Patient and public involvement is embedded into the 'business as usual' work of the Equality and Access Team (E&A) and below are some highlights of the activities undertaken throughout 2017/18:

- Health & Wellbeing partnerships in the Leys, Rose Hill, Barton, Wood Farm, Littlemore.

- In November, a travel survey with patients at Banbury Health Centre, which informed us that the current site was very important to those patients who used it; accordingly OCCG is supporting the continuation of the service.
- Raising awareness of NHS services to a group of Syrian Refugees in Abingdon
- Participation in the Oxford multi-agency refugees, asylum seeker and vulnerable migrant co-ordination group, which will be taking forward a successful funding bid from the Controlling Migration Fund.
- Face to face survey with patients and carers from Luther Street Practice, a GP Practice which provides healthcare to homeless people in Oxford.

OCCG continues to work closely with young people through VOXY (Voice of Oxfordshire's Youth) which was launched at the end of 2016 and was the idea of a young person and past member of Oxfordshire's Youth Parliament. This year the work includes:

- Oxfordshire Children and Young People's Plan (Nov 2017 – Present)
- Oxfordshire's Healthcare Transformation Programme: A workshop with VOXY members was held to identify important themes and healthcare priorities for young people for OCCG's Transformation work. VOXY members were invited to spread the word at their schools and share these views on social media with the hashtag #IfIrantheNHS so that OCCG could collate all views.
- Developing mental health services in Oxfordshire.

For more information about our public engagement activity over the past year please read our public involvement report and see our activity grid available on our website www.oxfordshireccg.nhs.uk

Responding to an emergency

Under the Civil Contingency Act 2004, CCGs have been designated Category Two responders and have a duty to co-operate and share information in an emergency. As a Category Two responder, OCCG has roles and responsibilities in emergency preparedness, resilience and response (EPRR) are to:

- Co-operate and share relevant information with Category One responders
- Engage in cross-sector planning through Local Health Resilience Partnership
- Support NHS England (South East) in discharging its EPRR functions and duties locally
- Include relevant EPRR elements in contracts with providers
- Ensure that resilience is 'commissioned in' as part of standard provider contracts and to reflect risks identified through wider, multi-agency planning
- Reflect the need for providers to respond to routine operational pressures (e.g. Winter)
- Enable NHS funded providers to participate fully in EPRR exercises and testing programmes as part of the NHS England (South East) assurance process

- Provides commissioned providers with a route of escalation on a 24/7 basis if they fail to maintain their professional levels
- Respond to reasonable requests to assist and co-operate
- Support NHS England (South East) should any emergency require any NHS resources to be mobilised
- Support NHS England (South East) to effectively mobilise all applicable providers that support primary care services should the need arise.

OCCG is responsible for maintaining service delivery across the local health economy to prevent business as usual pressures becoming significant incidents.

All CCGs and NHS-funded providers are required to have an Accountable Emergency Officer who can take executive responsibility for leadership for EPRR. In OCCG it is the Director of Governance who holds this executive responsibility. A 24/7 director on call rota is in place to deal with any issues escalated to us by our providers and a 24/7 communications on call rota exists for media and communications issues.

OCCG was required to assess itself against the NHS Core Standards for EPRR as part of the annual assurance process with NHS England agreeing that OCCG is substantially compliant. An improvement plan was developed setting out required actions to ensure full compliance.

OCCG participates regularly in Exercise 'Talk Talk', a communication cascade exercise to test the flow of information between emergency responders across the health system in the Thames Valley. We also participated in the following exercises over the past year:

- Director on Call Training sessions designed to share learning as well as working through scenarios
- Strategic leadership in a crisis – preparing strategic staff for their role in leading the NHS response to disruptive challenges
- Communications emergency planning exercise with communications colleagues in agencies across Oxfordshire.

OCCG has incident response plans in place which are fully compliant with the NHS England Emergency Preparedness Framework 2013. OCCG regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Board.

Louise Patten
Accountable Officer
24 May 2018

ACCOUNTABILITY REPORT

Corporate Governance Report

Members' Report

OCCG is a clinically led membership organisation made up of 70 general practices, grouped into six localities. Each locality's population has different needs and working this way allows individual GP practices in the localities to reflect local health needs in the services that we buy. The GP practices within each locality meet on a regular basis to discuss progress on their priorities for healthcare in their area of the county. Each locality has a GP who is a Locality Clinical Director and is a member of the OCCG Board. Each locality has a patient and public forum that works closely with the locality group of GPs to ensure patient views are included in discussions and decisions about healthcare in their area and throughout Oxfordshire.

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states:

'The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.'

The responsibilities of the OCCG Board are detailed in its constitution which is available on OCCG website here.

The Membership Body is represented on the Board through the six Locality Clinical Directors who are appointed in line with their locality constitutions. Through adopting the constitution, the Membership Body has agreed that the Board 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 of strategic risks

Membership Practices and Profiles

As of 31 March 2018, our localities and practices included:

North East Oxfordshire

There are 7 GP practices in the locality with a combined population more than 83,500. The Locality Clinical Director is Dr Stephen Attwood, who is supported by Dr Will O'Gorman. The practices are:

1. Alchester Medical Group
2. Bicester Health Centre
3. Gosford Hill Medical Centre
4. Islip Medical Practice
5. Montgomery House Surgery
6. The Key Medical Practice
7. Woodstock Surgery

North Oxfordshire

There are 12 GP practices in the locality with a population of around 112,300. The Locality Clinical Director is Dr Paul Park, who is supported by Dr Shelley Hayles as deputy. The 12 practices are:

1. Banbury Health Centre
2. Bloxham Surgery
3. Chipping Norton Health Centre
4. Cropredy Surgery
5. Deddington Health Centre
6. Hightown Surgery
7. Horsefair
8. Sibford Gower Surgery
9. West Bar Surgery
10. Windrush Surgery (Banbury)
11. Woodlands Surgery
12. Wychwood Surgery

Oxford City

In 2017/18 there are 21 GP practices in the locality with a population of over 223,000. The Locality Clinical Director is Dr David Chapman supported by Dr Merlin Dunlop, Dr Karen Kearley and Dr Andy Valentine. The practices are:

1. 19 Beaumont Street
2. 27 Beaumont Street
3. 28 Beaumont Street
4. Banbury Road Medical Centre
5. Bartlemas Surgery
6. Botley Medical Centre

7. Hedena Health
8. Cowley Road Medical Practice
9. Donnington Medical Partnership
10. Hollow Way Medical Centre
11. Jericho Health Centre
12. King Edward Street
13. Luther Street Medical Centre
14. Manor Surgery
15. Observatory Medical Practice
16. South Oxford Health Centre
17. St Bartholomews Medical Centre Cowley
18. St Clements Surgery
19. Summertown Medical Group
20. Temple Cowley Health Centre
21. The Leys Health Centre

South East Oxfordshire

There are 10 GP practices in the locality with a population of around 93,500. The Locality Clinical Director is Dr Ed Capo-Bianco. The 10 practices are:

1. Bell Surgery
2. Goring & Woodcote Health Centre
3. Hart Surgery
4. Mill Stream Surgery
5. Morland House Surgery
6. Nettlebed Surgery
7. Rycote Surgery
8. Sonning Common Health Centre
9. Wallingford Medical Centre
10. Watlington & Chalgrove Surgery

South West Oxfordshire

There are 12 GP practices in the locality with a population of around 148,000. The Locality Clinical Director is Dr Jonathan Crawshaw. The 12 practices are:

1. Abingdon Surgery
2. Berinsfield Health Centre
3. Church Street Practice
4. Clifton Hampden Surgery
5. Didcot Health Centre
6. Long Furlong Medical Centre
7. Malthouse Surgery
8. Marcham Road Health Centre
9. Newbury Street Practice
10. Oak Tree Health Centre

11. White Horse Practice
12. Woodlands Medical Centre

West Oxfordshire

There are 8 GP practices in the locality with a population of nearly 81,000 patients. Dr Miles Carter is the Locality Clinical Director who is supported by Dr Amar Latif as deputy. These practices are:

1. Bampton Surgery
2. Broadshires Health Centre
3. Burford Surgery
4. The Charlbury Surgery
5. Cogges Surgery
6. The Eynsham Medical Group
7. The Nuffield Health Centre
8. Windrush Health Centre

Members of the Board

The names of the Clinical Chair and Chief Executive of OCCG are:

- Dr Kiren Collison, Clinical Chair (from 1 December 2017)
- Louise Patten, Chief Executive (Accountable Officer from 1 January 2018)

The Board of OCCG comprises GP representatives, lay members, executive directors and representatives from Public Health, Adult Social Care and an external Medical Specialist. Individual profiles are available on our website here. The composition of the Board as of 31 March 2018 includes:

- Dr Stephen Attwood, North East Locality Clinical Director
- Dr Ed Capio-Bianco, South East Locality Clinical Director
- Dr Jonathan Crawshaw, South West Locality Clinical Director
- Dr Miles Carter, West Locality Clinical Director
- Dr David Chapman, Oxford City Clinical Director
- Dr Kiren Collison, Clinical Chair (from December 2017)
- Heidi Devenish, Business Practice Manager at the Summertown Group Practice, Oxford representing the views of practice managers across Oxfordshire (temporary position from 1 November 2017)
- Roger Dickinson, Lay Member Lead for Governance, Vice Chair and Audit Committee Chair, Remuneration Committee Chair
- Diane Hedges, Chief Operating Officer
- Gareth Kenworthy, Director of Finance
- Dr Jonathan McWilliam, Director of Public Health, Oxfordshire County Council
- Catherine Mountford, Director of Governance

- Dr Paul Park, North Oxfordshire Locality Clinical Director
- Louise Patten, Chief Executive (from January 2018)
- Dr Guy Rooney, Medical Specialist Advisor
- Duncan Smith, Lay Member for Finance, Finance Committee Chair and Oxfordshire Primary Care Commissioning Committee Chair.
- Kate Terroni, Director of Adult Social Services, Oxfordshire County Council
- Prof Louise Wallace, Lay Member for Public Participation and Involvement (PPI) and Quality Committee Chair
- Sula Wiltshire, Director of Quality and OCCG Lead Nurse

Statement of Disclosure to Auditors

Each individual who is a member of the Board at 31 March 2018 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 50 for information about the committees of the board including membership and attendance.

The Board member Register of Interests is available on our 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 has appointed Louise Patten to be the Accountable Officer of NHS Oxfordshire CCG.

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

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

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

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

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

- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,
- Prepare the financial statements on a going concern basis.

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

I also confirm that:

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

Louise Patten
Accountable Officer
24 May 2018

Governance Statement

Introduction and context

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

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

As at 1 April 2018, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

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

The responsibilities of the Board are detailed in the NHS Oxfordshire Clinical Commissioning Group Constitution. Supporting documents to the Constitution include the Scheme of Delegation, Standing Orders and responsibilities of the members of the Board.

Through adoption of the Constitution the Practice Members have agreed that the Board 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 of strategic risks

The Practice Members are represented on the Board through the six Locality Clinical Directors who are appointed in line with their respective Locality Constitutions.

In accordance with its Constitution, the Board has held eight meetings in public in this period. All meetings were quorate in terms of executive and lay member representation. A table of attendance is included in Appendix A on page 83.

The 2017/18 Board agenda has focused on organisational objectives, national priorities and the local health economy's priorities in the Operational Plan. The Board has also held workshops on strategic and corporate objectives.

Standing Agenda items include The Chief Executives Report, Locality Clinical Director Reports, Integrated Performance Report, Finance Report, Corporate Governance Report, Strategic Risk Register and Board Committee Reports. In addition to the standing agenda items the Board agenda in 2017/18 has included reporting on:

- Reports and Business Case for Phase One of the Transformation Programme
- 360 Degree Stakeholder Survey
- Mazars Mortality Review
- Annual Safeguarding Report
- Annual Emergency Preparedness, Resilience and Response Report
- Health Inequalities Commission Implementation Plan
- Children and Young People's Plan

Board Committees

Audit Committee

The Audit Committee provides an independent and objective view of the proper stewardship of OCCG's resources and assets by overseeing internal and external audit services, reviewing internal control systems and processes, monitoring compliance with Standing Orders and Prime Financial Polices, reviewing schedules of losses and compensations, reviewing the information prepared to support the controls of assurance

statements, overseeing risk management arrangements and making recommendations to the Board. The role of the Committee includes integrated governance, statutory reporting and assurance in respect of the principal risks and it will monitor and review the systems and frameworks that are in place to manage organisational risk.

The Committee is Chaired by the Vice Chair of the Board with the remaining members comprising two lay members (including a qualified accountant), and one Locality Clinical Director. The following officers of OCCG and external representatives are expected to be in attendance: the Director of Finance, the Director of Governance and representatives from internal and external audit. A table of attendance is included at Appendix A on page 83.

The Audit Committee met six times during 2017/18 and fulfilled its remit and responsibilities as detailed in the annual work plan. The Committee received regular updates on risk, external audit, internal audit and security management, general audit matters and financial matters to ensure that risks were appropriately prioritised and adequately controlled and mitigated.

The following internal audits have been received:

- Conflicts of Interest
- Procedures of Limited Clinical Value
- Board Assurance Framework
- IG Toolkit
- Informatics – Cybersecurity
- Delayed Transfers of Care
- NICE Governance
- Performance Management
- Financial Management and Saving Plan Delivery

The minutes of the Audit Committee are made available to the public with Board papers.

The Committee has undertaken a self-assessment of its effectiveness using a self-assessment checklist. Actions arising from this self-assessment will be included in the work plan for 2018/19.

Finance Committee

The remit of the Finance Committee is to develop the financial strategy for OCCG, scrutinise and approve medium term financial plans and the annual budget, monitor in year financial performance and approve the use of contingency reserves.

The Committee comprises at least six Board members: three Lay Board members (including at least one qualified accountant), one Locality Clinical Director, the Director of Finance and Chief Operating Officer. The Lay Member (Finance) undertakes the role

of Chair. Other members of OCCG management and external advisers may be invited to attend where appropriate. A table of attendance is included in Appendix A on page 83.

The Finance Committee met seven times during 2017/18. In addition to standing agenda items reporting on progress on business cases and financial risk, the Committee received reports and updates including:

- Transformation Plan
- Capital Investment in Primary Care Estates
- Contracting and Commissioning Intentions
- Integrated Respiratory Team Project
- Support to Care Homes Scheme Evaluation

The minutes of the Finance Committee are made available to the public with the Board papers.

The Committee has undertaken a review of its performance and included the outcome in an annual report.

Quality Committee

The role of the Quality Committee is to provide assurance of the quality and performance of services commissioned and to promote a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience. The Committee oversees arrangements for safeguarding, co-operating with the local authority in the operation of the Safeguarding Children and Safeguarding Adults Boards.

The Quality Committee is Chaired by the lay member with responsibility for patient and public involvement who is a voting member along with another lay member from the Board, the Director of Quality, two locality clinical representatives, Specialist Medical Adviser, Chief Operating Officer and the Director of Governance. Non-voting ex-officio attendees of the committee comprise Clinical Directors of Quality for acute and community services and primary care, Deputy Director of Quality, Deputy Director Joint Commissioning Oxfordshire County Council (OCC), Deputy Director Public Health (OCC) and a patient representative. A table of attendance is included in Appendix A page 83.

The Quality Committee met six times during 2017/18 and in addition to standing items on quality and performance reports, risk register, patient experience, clinical effectiveness inspections and reviews the committee has received reports and updates on:

- Annual Safeguarding Report
- Strategic Review of Domestic Abuse

- CQC Place Based Inspections
- Special Education Needs Disability review
- Children and Young People Plan
- NICE Annual Report
- IFR and Prior Approval Annual Report
- Infection Control Annual Report
- Annual Prescribing Plan
- Horton General Hospital Midwife led Unit and ambulance transfers to the John Radcliffe Hospital

The meeting held on 26 October 2017 was not quorate therefore decisions to approve the Policy for Commissioning and Monitoring of NICE guidance were ratified via email.

Remuneration Committee

The role of the Remuneration Committee is to advise on appropriate remuneration levels and terms of service for the Executive Team and Clinical Leads. The Committee also sets the framework within which the terms and conditions of senior managers and clinicians are developed and agreed and receives reports on the performance of the Accountable Officer and individual Directors.

The Remuneration Committee is Chaired by the Lay Vice Chair of the Board with the Chair and two other lay members making up the membership. The Accountable Officer and Human Resources lead and other external experts are asked to support the Committee as required.

The Remuneration Committee met 7 times during 2017/18 and fulfilled its remit and responsibilities focusing on:

- A redundancy case
- Re-appointment of lay members
- Recruitment of the Clinical Chair and Chief Executive
- Pension Auto-enrolment
- VSM pay/Directors' Terms and Conditions/Directors' Pay
- Appointment of interim Chief Executive

A table of attendance for meetings is included at Appendix A on page 83.

Oxfordshire Primary Care Commissioning Committee (OPCCC)

The role of the Committee is to carry out the functions relating to the commissioning of primary medical services in Oxfordshire, including agreeing primary care aspects of the overall OCCG commissioning strategy, providing assurance to the Board and NHS England on quality, performance and finance of all services commissioned from primary care which incorporate the delegated funding and funding from the core OCCG allocation, design of local incentive schemes, newly designed enhanced services,

approving practice mergers and agreeing and monitoring a financial plan and budget, risk assessment, performance framework and annual workplan.

The Committee is chaired by the Lay Member (Finance). Other members include Lay Vice Chair, Chief Executive, Chief Operating Officer, Director of Governance, Medical Specialist Advisor and two GPs (Clinical Chair or Deputy Chair and one other), Healthwatch, Patient Representative and NHS England Representative. A table of attendance is included at Appendix A on page 83.

The Committee met six times during 2017/18. As well as standing agenda items on finance, quality, Head of Primary Care update and risk register the committee has received papers on the following:

- Primary Care Framework
- GP Forward View
- Workforce Plan
- Primary Care Estate
- Primary Care Plan/Priorities for 2017/2018
- Primary Care Locality Plans
- Addressing outcome of SoS referral by HOSC for Deer Park

All meeting papers and minutes are published on the OCCG website.

UK Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. 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 2018 and up to the signing of the statement, we complied with the provisions as set out in the Code and applied the principles of the Code.

Discharge of Statutory Functions

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

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

Other sources of assurance

Internal Control Framework

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

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

The Governance Team co-ordinates production of risk registers, offers advice and training (when required) and works with OCCG Directors via the bi-monthly Directors Risk Review meeting. This meeting is chaired by the Director of Governance and attended by all Directors. The meeting looks at identifying new risk areas and managing them effectively. It reviews the quality of recording of its current risks including an up to date description of current ratings; this gives oversight to ensure all risks are managed appropriately. The Governance Team also maintains the OCCG risk cycle and ensures that timely reminders are set to risk managers for each risk cycle as per Board and Board committee meetings.

Proposed new risks are presented as drafts to the Executive at the Directors Risk Review meeting for approval. The meeting is organised to ensure that all risks are approved by the Executive ahead of inclusion on the risk register and presented to OCCG Board. Strategic risks are only closed with approval from the Executive while operational risks are closed with the approval of a directorate head of service.

Annual audit of conflicts of interest management

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

Our internal auditors carried out the annual audit of conflicts of interests with an overall assurance assessment of reasonable assurance. The following were the key findings from the audit:

- Conflicts of Interest Policy requires refresh

- Registers to be updated to include type of interest, date from / to of interest and action taken to mitigate risk
- Gifts and Hospitality register will be enhanced to include the reason for accepting or declining offer as per latest guidance
- Register of Procurement Decisions will be enhanced to include a summary of the conflicts in relation to the decision and how this was managed
- Mandatory training on Conflicts of Interest will be adopted in compliance with national guidance; this included identification of staff for who it is mandatory.

Data Quality

Acute Sector

Data quality in the acute sector is much improved as is awareness of the impact when it is not. Commissioning Support Unit colleagues are working with providers on an on-going basis and are implementing reporting strategies to mitigate the impact on reporting. A national and local data set (SUS-SLAM) reconciliation report across providers now exists for Oxfordshire and is routinely used. The Commissioning Support Unit is now developing a SUS-SLAM reconciliation module across their footprint to ensure these key measures can be routinely produced in a meaningful manner.

Understanding among OCCG staff of the importance and role of Information Requirements detailed in Schedule 6 of the national contract is much higher and work will continue to ensure staff understand the content.

Joint working between provider performance management and analytics is now well established. Progress still needs to be made where OCCG is not the lead commissioner.

Data Quality Improvement Plans (DQUIPs) are automatically monitored as part of the normal contract management processes and issues escalated from Finance and Information Group (FIG) to the Contract Review Meetings (CRM) as appropriate for each contract.

Non Acute

Very significant progress has continued to be made in 2017/18 for both community and mental health contracts in Oxfordshire. We now have a well-established productive relationship which enables us jointly to drive improvements. For example, we are moving to a single stable data source for community hospital activity and are jointly using said data to develop evidence based indicative activity plans for the contract.

The depth of knowledge and understanding associated with the meaning of key statistics and data sources is increasing, not only among data specialists but also among commissioners. This deeper level of understanding is changing the nature of the discussion with the provider when challenging apparent performance issues.

There have been difficulties with the collation of the newly mandated national datasets , due to national delays, but we are working together to find solutions so that we can move away from local - less stable, more expensive and less comprehensive, datasets.

We have an established route to challenge, improve and resolve data issues in the community.

In mental health an alternative to the highly problematic mental health minimum data set (MHMDS) has been successfully sourced from the provider and has informed the assessment of delivery against agreed outcome measures. We are preparing to move to the nationally mandated dataset as it is now available to the Commissioning Support Unit. When that is stable, the local data flow will be ended, thereby reducing the burden on all stakeholders.

Overall

The approach to data sourcing from providers is focused on sourcing good quality nationally mandated datasets, thereby also driving improvement in national data collections. Local data sets are only sourced where nationally mandated datasets do not exist. This often covers areas of innovation and is therefore critical to evidence. DQUIPs are included in all contracts and now include tighter requirements and penalties. They will be monitored as part of the normal contract management processes and issues escalated from FIG to the CRMs as appropriate for each contract in both the acute and non-acute sectors.

The multidisciplinary approach adopted by the Commissioning Support Unit is enabling progress on several contracts to be achieved.

We have also discussed Data Quality with the Audit Committee and are building data quality measures in some of our core corporate reports such as the Integrated Performance Report.

Programme Management Office processes will now require project managers to have considered data source and quality as part of their business case development in order to secure authorisation to proceed with their project.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their responsibilities.

Every year OCCG need to complete an Information Governance Assessment (IG Toolkit) and submit to the Department of Health and Social Care. Data flow mapping and the asset register are part of the submission. Data flow mapping is the process of capturing all inbound and outbound data that is valuable to an organisation; whilst the information asset register is a log / register of all the information assets that the organisation holds. Both of these inform the Business Continuity Plans for the organisation and are therefore crucial for the organisation's functioning.

OCCG has made preparations for the implementation of the General Data Protection Regulation (GDPR) due to come into force in May 2018. The IG Toolkit for 2018/19 will be revised in light of this. OCCG submitted the 2017/18 Information Governance Toolkit with a score of 79% achieving at least level two against all 28 requirements.

Business Critical Models

OCCG does not own and has not developed any business critical models that have supported its planning in 2017/18. Our Commissioning Support Unit partner holds models that may be used on our behalf but these have not been used to date. We are aware of the recommendations for the public sector made in the Macpherson Report and will apply them as and when we place reliance on business critical models to support OCCG.

Control Issues

As identified in the Month 9 Governance Statement return NHS Constitutional requirements are not being met by providers. To mitigate this winter pressures funding has been agreed by NHS England to deliver improvements in A&E performance; DTOC trajectory and action plan in place covering Home Assessment Reablement Team, Trusted Assessor, hard to place patients, high impact changes and workforce and a medium term Referral to Treatment plan has been proposed and is in final negotiation.

In addition there is a risk to implementation of transformation proposals as these are subject to challenge through judicial review and a referral to the Secretary of State. The temporary closure of consultant-led maternity services at the Horton General Hospital in Banbury remains in place for patient safety reasons.

Counter fraud arrangements

The Chief Finance Officer (CFO) is the executive board member with responsibility for fraud, bribery and corruption. The CFO approves the annual work plan and liaises with the Local Counter Fraud Specialist in relation to progress against the plan, referrals and other counter fraud issues.

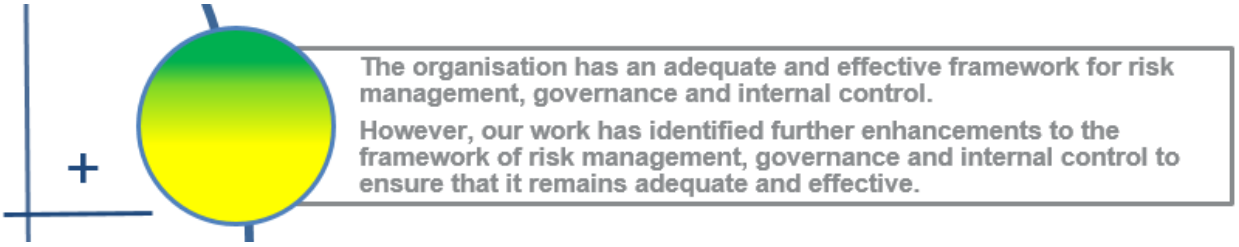
Head of Internal Audit Opinion

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:

1.1 The opinion

For the 12 months ended 31 March 2018, the head of internal audit opinion for Oxfordshire Clinical Commissioning Group is as follows:

Head of internal audit opinion 2017/18



During the year, a number of reasonable assurance reports have been issued which highlight areas for improvement in the control framework. In addition, we were requested by OCCG to undertake additional work relating to Continuing Healthcare and the financial position in relation to this. Although this work was undertaken on an advisory basis, it did highlight areas of weakness in the management of CHC spend. Therefore, we have considered this as part of our overall opinion for the year.

Please see page 62 for the full range of annual opinions available to us in preparing this report and opinion.

1.2 Scope and limitations of our work

The formation of our opinion is achieved through a risk-based plan of work, agreed with management and approved by the audit committee. Our opinion is subject to inherent limitations, as detailed below:

- the opinion does not imply that internal audit has reviewed all risks and assurances relating to the organisation;
- the opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework. As such, the assurance framework is one component that the board takes into account in making its annual governance statement (AGS);
- the opinion is based on the findings and conclusions from the work undertaken, the scope of which has been agreed with management;
- the opinion is based on the testing we have undertaken, which was limited to the area being audited, as detailed in the agreed audit scope;
- where strong levels of control have been identified, there are still instances where these may not always be effective. This may be due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance;
- due to the limited scope of our audits, there may be weaknesses in the control system which we are not aware of, or which were not brought to attention; and
- it remains management's responsibility to develop and maintain a sound system of risk management, internal control and governance, and for the prevention and detection of material errors, loss or fraud. The work of internal audit should not been seen as a substitute for management's responsibilities around the design and effective operation of these systems.

1.3 Factors and findings which have informed our opinion

We have issued positive assurance opinions in relation to the following reviews:

- Localities Governance and Engagement – Substantial Assurance
- Performance Management – Reasonable Assurance
- Financial planning and Saving Plan Delivery – Reasonable Assurance
- Conflicts of Interest – Reasonable Assurance
- Primary Care Commissioning – Reasonable Assurance
- Risk Management and Assurance – Reasonable Assurance

We have not issued any Partial or No Assurance opinions during 2017/18.

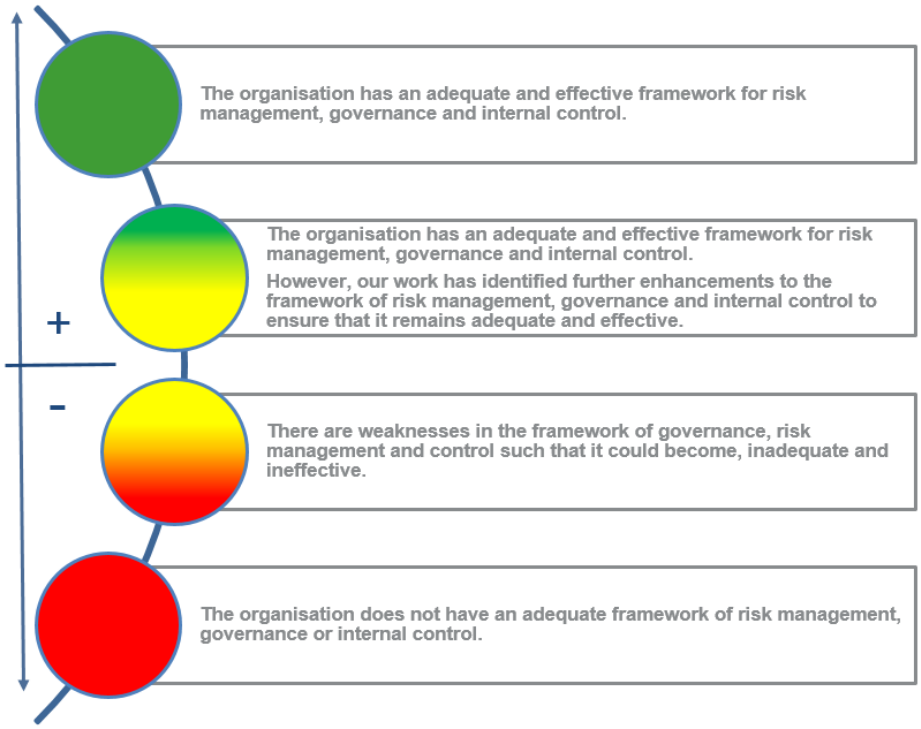
The management actions identified during our reviews and the findings of the CHC work have been considered as part of our opinion process.

1.4 Topics judged relevant for consideration as part of the annual governance statement

Based on the work we have undertaken on OCCG's system on internal control, we do not consider that within these areas there are any issues that need to be flagged as significant control issues within the Annual Governance Statement (AGS). However, we would expect OCCG to consider in the formulation of the AGS the internal control weaknesses identified within our partial assurance opinions summarised above, along with the actions being taken to address the issues identified.

Appendix 1: Annual opinions

The following shows the full range of opinions available to us within our internal audit methodology to provide you with context regarding your internal audit opinion.

Annual opinions	Factors influencing our opinion
	The factors which are considered when influencing our opinion are: • inherent risk in the area being audited; • Limitations in the individual audit assignments • The adequacy and effectiveness of the risk management and / or governance control framework • The impact of weakness identified • The level of risk exposure • The response to management actions raised and timeliness of actions taken

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 that 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 address weaknesses, for example responses to audit recommendations and ensure continuous improvement of the system is in place.

Conclusion

No significant control issues have been identified.

Louise Patten
Accountable Officer
24 May 2018

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 in on page 54 and 79.

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 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 acknowledge and commit to complying with the requirement to seek pre-approval from NHS England for salaries in excess of £142,500, we have done this in one case for the Accountable Officer role.

Senior Manager Remuneration (including salary and pension entitlements) 2017/18

Name	Title	Oxfordshire CCG Salary & Fees (Bands of £5000) £000	Taxable benefi (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
Julie Anderson	Locality Clinical Director	5-10	0	0	0	0-2.5	5-10
Stephen Attwood	Locality Clinical Director	60-65	0	0	0	0-2.5	60-65
Andew Burnett	Locality Clinical Director	0-5	0	0	0	0-2.5	0-5
Ed Capo-Bianco	Locality Clinical Director	50-55	0	0	0	170-172.5	220-225
Miles Carter	Locality Clinical Director	60-65	0	0	0	12.5-15	75-80
David Chapman	Locality Clinical Director	60-65	0	0	0	0-2.5	60-65
Kiren Collison	Clinical Chair	30-35	0	0	0	0-2.5	30-35
Jonathan Crawshaw	Locality Clinical Director	55-60	0	0	0	177.5-180	235-240
Diane Hedges	Chief Operating Officer and Deputy Chief Exective	115-120	0	0	0	22.5-25	140-145
Gareth Kenworthy	Director of Finance	105-110	0	0	0	25-27.5	135-140
Stuart MacFarlane	Practice Manager Representative	0-5	0	0	0	0-2.5	0-5
Joe McManners	Clinical Chair	50-55	0	0	0	22.5-25	70-75
Catherine Mountford	Director of Governance	100-105	0	0	0	15-17.5	115-120
Paul Park	Locality Clinical Director	70-75	0	0	0	0-2.5	70-75
Louise Patten	Chief Executive	30-35	0	0	0	27.5-30	55-60
Guy Rooney	Medical Specialist Advisor	10-15	0	0	0	0-2.5	10-15
David Smith	Chief Executive	120-125	0	0	0	0-2.5	120-125
Ursula Wiltshire	Director of Quality and Innovation	100-105	0	0	0	15-17.5	115-120
Mike Delaney	Independent Lay Member	5-10	0	0	0	0	5-10
Roger Dickinson	Independent Lay Member, Lead for Governance and Vice Chair	15-20	0	0	0	0	15-20
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

Note:

- Louise Patten - seconded from NHS Chiltern Clinical Commissioning Group
- David Smith was Chief Executive until 31 December 2017
- Joe McManners was Clinical Chair until 30 November 2017

Senior Manager Remuneration (including salary and pension entitlements) 2016/17

Name	Title	Oxfordshire CCG Salary & Fees (Bands of £5000) £000	Taxable benefi (rounded to nearest £100) £00	Annual Performance Related Bonuses (Bands of £5000) £000	Long Term Performanc Related Bonuses (Bands of £5000) £000	All Pension Related Benefits (Bands of £2500) £000	TOTAL Oxfordshire CCG (Bands of £5000) £000
Julie Anderson	Locality Clinical Director	70-75	0	0-5	0-5	0-2.5	70-75
Stephen Attwood	Locality Clinical Director	60-65	0	0-5	0-5	0-2.5	60-65
Andew Burnett	Locality Clinical Director	45-50	0	0-5	0-5	0-2.5	45-50
Miles Carter	Locality Clinical Director	60-65	0	0-5	0-5	22.5-25	85-90
David Chapman	Locality Clinical Director	50-55	0	0-5	0-5	60-62.5	115-120
Diane Hedges	Chief Operating Officer and Deputy Chief Exective	115-120	0	0-5	0-5	25-27.5	140-145
Gareth Kenworthy	Director of Finance	105-110	0	0-5	0-5	30-32.5	135-140
Stuart MacFarlane	Practice Manager Representative	0-5	0	0-5	0-5	0-2.5	0-5
Joe McManners	Clinical Chair	75-80	0	0-5	0-5	17.5-20	95-100
Catherine Mountford	Director of Governance	100-105	0	0-5	0-5	22.5-25	125-130
Paul Park	Locality Clinical Director	75-80	0	0-5	0-5	27.5-30	105-110
Guy Rooney	Medical Specialist Advisor	5-10	0	0-5	0-5	0-2.5	5-10
David Smith	Chief Executive	160-165	0	0-5	0-5	0-2.5	160-165
Ursula Wiltshire	Director of Quality and Innovation	100-105	0	0-5	0-5	22.5-25	125-130
Mike Delaney	Independent Lay Member	10-15	0	0-5	0-5	0-2.5	10-15
Roger Dickinson	Independent Lay Member, Lead for Governance and Vice Chair	15-20	0	0-5	0-5	0-2.5	15-20
Duncan Smith	Independent Lay Member, Lead for Finance	15-20	0	0-5	0-5	0-2.5	15-20
Louise Wallace	Independent Lay Member, Lead for Patient Participation and Involvement	10-15	0	0-5	0-5	0-2.5	10-15

Note: Diane Hedges:- 01/04/2016 to 13/06/2016 Director of Delivery and Localities 14/06/2016 to 31/03/2017 as per Title above

Pension Benefits as at 31 March 2018

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 2018 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1st April 2017 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2018 £'000	Employer's contribution to stakeholder pension £'000
Ed Capo-Bianco	Locality Clinical Director		5-7.5	17.5-20	5-10	20-25	0	89	97	0
Miles Carter	Locality Clinical Director		0-2.5	0-2.5	10-15	25-30	149	14	164	0
David Chapman	Locality Clinical Director		0-2.5	0-2.5	35-40	85-90	671	22	700	0
Kiren Collison	Clinical Chair		0-2.5	0-2.5	5-10	10-15	82	0	77	0
Jonathan Crawshaw	Locality Clinical Director		7.5-10	7.5-10	10-15	10-15	21	81	109	0
Diane Hedges	Chief Operating Officer and Deputy Chief Exective		0-2.5	0-2.5	20-25	50-55	461	53	519	0
Gareth Kenworthy	Director of Finance		0-2.5	0-2.5	30-35	70-75	410	29	443	0
Joe McManners	Clinical Chair		0-2.5	0-2.5	15-20	30-35	178	15	202	0
Catherine Mountford	Director of Governance		0-2.5	2.5-5	35-40	110-115	722	46	775	0
Paul Park	Locality Clinical Director		0-2.5	0-2.5	15-20	40-45	262	0	249	0
Louise Patten	Chief Executive		0-2.5	0-2.5	20-25	30-35	432	11	479	0
Ursula Wiltshire	Director of Quality and Innovation		0-2.5	2.5-5	35-40	110-115	0	0	0	0

Note:

- Louise Patten - seconded from NHS Chiltern Clinical Commissioning Group
- Lay members do not receive pensionable remuneration.

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.

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 2017

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 2017 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1st April 2016 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2017 £'000	Employer's contribution to stakeholder pension £'000
Miles Carter	Locality Clinical Director		0-2.5	0-2.5	10-15	25-30	123	26	149	0
David Chapman	Locality Clinical Director		2.5-5	5-7.5	35-40	85-90	598	109	707	0
Diane Hedges	Chief Operating Officer and Deputy Chief Executi	(*)	0-2.5	0-2.5	20-25	50-55	422	39	461	0
Gareth Kenworthy	Director of Finance		0-2.5	0-2.5	25-30	70-75	359	51	410	0
Joe McManners	Clinical Chair		0-2.5	0-2.5	10-15	30-35	160	18	178	0
Catherine Mountford	Director of Governance		0-2.5	2.5-5	35-40	105-110	670	52	722	0
Paul Park	Locality Clinical Director		0-2.5	0-2.5	15-20	45-50	221	41	262	0
David Smith	Chief Executive	(**)	0-2.5	0-2.5	0	0	1,766	0	0	0
Ursula Wiltshire	Director of Quality and Innovation		0-2.5	2.5-5	35-40	105-110	0	0	0	0

Note: Lay members do not receive pensionable remuneration.

(*) Diane Hedges:- 01/04/2016 to 13/06/2016 Director of Delivery and Localities 14/06/2016 to 31/03/2017 as per Title above

(**) David Smith left Pension Scheme Sept 2015

Workforce Remuneration: Multiple Pay

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 2017/18 was £155-£160k (2016/17 was £160k to £165k) on an annualised basis. This was 3.2 times (2016/17 3.5 times) the median remuneration of the workforce, which was £48,514 (2016/17 £47,071).

In 2017/18, no employees (2016/17 no employees) received remuneration in excess of the highest paid director/member of the OCCG Board. Remuneration ranged from £13,000 to £157,000 (2016/17 £13,000 to £162,000).

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

Below outlines OCCG's sickness absence data from 1 April 2017 to 31 March 2018.

	2015/16	2016/17	2017/18
Total Days Lost	418	533	594
Average full time equivalent	85	89	94.5
Average working Days Lost	**4.9**	**6.0**	**6.3**

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 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.

We also proactively promote the health and wellbeing of staff through a programme of health and wellbeing initiatives. Events are organised throughout the year and have included a running and walking club, Christmas decoration competition, Christmas quiz, mindfulness programme, a charity swimathon and a cycle to work scheme. The work is supported by a number of health and wellbeing champions and won the 2018 Oxfordshire Sports Award for Active Workplace.

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.

Staff numbers and gender analysis

OCCG has a workforce comprised of employees from a wide variety of professional groups. At the end of 2017/18 OCCG employed 130 staff (headcount), of which 93 were women and 37 men. As of 31 March 2018, the Board of OCCG was made up of 6 women and 11 men. Below is a breakdown of gender analysis. The membership body of OCCG is made up of all 70 (as at 31 March 2018) GP practices within Oxfordshire; a breakdown of membership by gender is not available.

The below overleaf outlines the gender breakdown of staff:

	Female Headcount	Male Headcount	Total Headcount
CEO and Board	6	11	17
Very Senior Managers including GPs	11	10	21
All other Employees	76	16	92
Total Employees	93	37	130

The below table shows average number of people (headcount) employed by OCCG, which equated to an average of 93.45 whole time equivalent staff.

	Total Number	2017/2018 Permanently employed Number	Other Numbers	2017/2018 Total Number
Total		105	28	133
Of the above: Number of whole time equivalent (WTE) people engaged on capital projects	0	0	0	0

Trade union official facility time
OCCG has one trade union representative who worked 55 facility hours during 2017/18 at a cost of £1,180.13.

Expenditure on consultancy
Expenditure on consultancy was £1,188k in 2017/18 (£940k in 2016/17) as per Note 5 to the Accounts page 102.

Off Payroll Engagements

Under Treasury guidance PES (2013) 09, all public sector organisations are required to disclose information about high paid off payroll appointments:

i) For all off payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than 6 months:

	Number
Number of existing engagements as of 31 March 2018	1
Of which, the number that have existed:	
For less than one year at the time of reporting	1
For between one and two years at time of reporting	0
For between two and three years at time of reporting	0
For between three and four years at time of reporting	0
For four years or more at the time of reporting	0

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

ii) For all new off-payroll engagements between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of new engagements , or those that reached six months in duration, between 1 April 2017 and 31 March 2018	4
Of which:	
Number assessed as caught by IR35	4
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to department) and are on departmental payroll	0

Number of engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

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

	Number
Number of engagements of board members and senior officials with significant financial responsibility during the year	0
Number of individuals that have been deemed board members and / or senior officials with significant financial responsibility during the year. This figure should include both off-payroll and on-payroll engagements	6

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 2017/18

Exit packages cost (inc special payment element	Compulsory redundancies Number	Compulsory redundancies £s	Other agreed departures Number	Other agreed departures £s	Total Number	Total £s	Departures where special payments have been made Number	Departures where special payments have been made £s
Less than £10,000	0	0	0	0			0	0
£10,001 to £25,000	1	8,000	0	0	1	8,000	0	0
£25,001 to £50,000	0	0	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0	0	0

Over £200,001	0	0	0	0	0	0	0	0
Total CCG	1	8,000	0	0	1	8,000	0	0

Exit Packages 2016/17

Exit packages cost (inc special payment element	Compulsory redundancies Number	Compulsory redundancies £s	Other agreed departures Number	Other agreed departures £s	Total Number	Total £s	Departures where special payments have been made Number	Departures where special payments have been made £s
Less than £10,000	0	0	0	0			0	0
£10,001 to £25,000	0	0	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0	0	0
Total CCG	0	0	0	0	0	0	0	0

Ill-health Retirements

	2017/18 Number	2016/17 Number
Number of persons retired early on ill health grounds	0	0
Total additional pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme.

Analysis of Other Agreed Departures

The number and value of exit packages agreed in the year were:

	2017/18 Other Agreed Departures Number	2017/18 Other Agreed Departures £	2016/17 Other Agreed Departures Number	2016/17 Other Agreed Departures £
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of service*	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total CCG	0	0	**0**	**0**

The tables above report the number and value of any exit packages agreed in the financial year. Any expense associated with these departures may have been recognised in part or in full in a previous period.

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

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 2017/18.

Staff Policies

OCCG recognise and value the importance of maintaining positive working relationships with our staff and their representatives. The Staff Partnership Forum (SPF) is our joint management and staff forum for staff engagement and consultation. We have actively and successfully worked in partnership on a number of issues affecting our staff including the development and review of human resources policies. Policies are ratified by OCCG's Executive prior to publication.

The SPF is representative of our 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, a mindfulness programme and awareness raising campaigns. OCCG won the Active Workplace category at the Oxfordshire Sports Awards in January 2018.

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

- Monthly staff briefings led by the Executive Team which includes a question and answer session
- Monthly staff newsletter
- Staff surveys to drive improvement in staff experience
- Corporate website and intranet
- Staff development sessions

The results of the staff survey were assessed by the 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.

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.

The Organisational Development (OD) Steering Group was established to oversee the implementation of the internal OD plan. Following the development of OCCG's vision and values and the supporting behavioural framework all staff were appraised using a

values based approach. The OD Steering Group have developed a People and OD Plan enabling OCCG to make informed choices around funding and resourcing for developing the workforce and attracting, developing and retaining key talent within the organisation.

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. Our 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. We are also committed to supporting our employees to maximise their performance including making any reasonable adjustments that may be required on a case by case basis.

We are committed to implementing the new Workforce Race Equality Standards (WRES) and will work with those organisations we commission 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. Our 2017 WRES return is available on our website here.

Equality and Diversity
For a full account of the Workforce race Equality Standard and how we give 'due regard' to eliminating discrimination please see page 36 of this report. Information is also available on www.nhs.uk/mynhs

Health and safety
We recognise 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. OCCG requires all workers to equally accept their responsibilities as part of the development of a true safety culture and we aim to ensure the achievement of high standards in relation to the provision of health and safety arrangements and the continued development of the safety culture and the well-being of staff.

OCCG's health and safety policy covers display screen equipment, fire safety, first aid, manual handling, lone working, new and expectant mothers and work related stress.

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 analysis of staff numbers and gender analysis and related narrative notes on pages 70 and 71, the tables of salaries and allowances of senior managers and related narrative notes on page 65 and 66, pension benefits of senior managers and related narrative on pages 67 and 68, exit packages and related narrative on pages 73 and 74 and the pay multiples and related narrative notes on page 69.

Louise Patten
Accountable Officer
24 May 2018

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 2017/18 there is nothing to disclose apart from losses as outlined below. An audit certificate and report is also included in this Annual Report (see page 80).

	Total Number of Cases 2017-18 Number	**Total Value of Cases 2017-18 £'000**	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000
Administrative write-offs	0	0	4	50
Fruitless payments	0	0	0	0
Store losses	0	0	0	0
Book Keeping Losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	0	0	0	0
Claims abandoned	0	0	0	0
Total	**0**	**0**	**4**	**50**

Louise Patten
Accountable Officer
24 May 2018

Independent Auditor's Report to the Members of the Board of Oxfordshire Clinical Commissioning Group

Opinion

We have audited the financial statements of Oxfordshire CCG for the year ended 31 March 2018 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 21. 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 2017-18 HM Treasury's Financial Reporting Manual (the 2017-18 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2017/18 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 Oxfordshire CCG as at 31 March 2018 and of its net operating costs for the year then ended; and
- have been properly prepared 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 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.

Use of our report

This report is made solely to the members of the Governing Body of Oxfordshire CCG 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.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Clinical Commissioning Group's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The other information comprises the information included in the annual report on pages 1-88, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information.

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.

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

We have nothing to report in this regard.

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

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health and Social Care Act 2012 and the Accounts Directions issued thereunder.

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 2018.

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 set out on pages 48-49, 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 is also responsible for ensuring the regularity of expenditure and income.

In preparing the financial statements, the Accountable Officer is responsible for assessing the Clinical Commissioning Group'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 have 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. 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.

Auditor's responsibilities for the audit of the financial statements

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

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at 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 criterion issued by the Comptroller and Auditor General in August 2017, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

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

We certify that we have completed the audit of the accounts of Oxfordshire CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Maria Grindley (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Reading
24 May 2018

Glossary of Terms

Antimicrobials: medicines such as antibiotics and antifungals used to treat bacterial or fungal infections

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 doctors at the head of the Clinical Commissioning Groups.

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 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

Hyper Acute Stroke Unit: brings experts and equipment under one roof to provide world-class treatment 24 hours a day , such as thrombectomy (mechanical removal of blood clots) and thrombolysis (clot busting drugs) reducing death rates and long-term disability

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

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

Outcomes Based Contract (OBC): a form of contract between commissioners and health providers which measures the success of healthcare by the results that matter to patients, rather than the number of patients seen. Patients also have a say in what they want success to look like.

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.

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

Rapid Access Care Unit (RACU): the main function of the centre is to diagnose and treat patients (usually frail elderly) deemed to be at risk of needing emergency admission to A&E. They can be admitted for assessment, treatment and discharged to prevent unnecessary admission to hospital if appropriate

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.

Sip feeds: nutritional drinks prescribed for people who may be malnourished as a result of poor health

Appendix A: Table of Attendance for Board and Committee Meetings (Membership in line with Constitution dated 14 January 2016)

Board

Name	25/05/2017	20/06/2017	27/07/2017	10/08/2017	09/28/2017	30/11/2017	25/01/2018	29/03/2018
Attwood, Stephen	✓	✓	✓	✓	✓	✓	✓	✓
Capo-Bianco, Ed	✓	✓	✓	✓	✓	✓	✓	✓
Carter, Miles	✓	✓	✓	✓	Apols[14]	✓	Apols	✓
Chapman, David	✓	✓	✓	✓	✓	✓	✓	✓
Collison, Kiren	N/A	N/A	N/A	N/A	N/A	N/A	✓	✓
Crawshaw, Jonathan	✓	✓	Apols	✓	✓	Apols	✓	Apols
Kenworthy, Gareth	✓	✓	Apols	✓	✓	✓	✓	✓
McManners, Joe	✓	✓	Apols	✓	✓	✓	N/A[15]	N/A
Park, Paul	✓	Apols	✓	✓	✓	✓	✓	✓
Patten, Louise	N/A	N/A	N/A	N/A	N/A	N/A	✓	✓
Rooney, Guy	✓	Apols	✓	Apols	✓	✓	Apols	✓
Smith, David	✓	✓	✓	✓	✓	✓	N/A	N/A
Smith, Duncan	✓	✓	✓	✓	✓	✓	✓	✓
Wallace, Louise	✓	✓	✓	✓	✓	✓	✓	✓
Wiltshire, Sula	Apols	✓	✓	✓	✓	✓	✓	✓

[14] Apols – Apologies given for meeting
[15] N/A – not applicable

Audit Committee

Name	20/04/2017	24/04/2017	23/05/2017	22/06/2017	19/10/2017	21/02/2018
Carter, Miles	Apols	✓	✓	✓	Apols	✓
Dickinson, Roger	✓	✓	✓	✓	✓	✓
Delaney, Mike	✓	✓	✓	✓	Apols	Apols
Smith, Duncan	✓	✓	✓	✓	✓	✓
Mountford, Catherine	✓	✓	✓	✓	Apols	✓
Kenworthy, Gareth	Apols	Apols	✓	✓	✓	✓

Finance Committee

Name	20/04/2017	23/05/2017	22/06/2017	25/07/2017	26/09/2017	23/11/2017	23/01/2018	22/03/2018
Delaney, Mike	✓	✓	✓	✓	Apols	Apols	Apols	N/A
Dickinson, Roger	✓	✓	✓	✓	✓	✓	✓	✓
Hedges, Diane	Deputised	✓	✓	✓	✓	✓	✓	✓
Kenworthy, Gareth	Apols	✓	✓	Apols	✓	✓	✓	✓
Park, Paul	✓	✓	Apols	✓	Apols	✓	Apols	✓
Patten, Louise	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Apols
Smith, David	Apols	✓	✓	✓	✓	✓	✓	N/A
Smith, Duncan	✓	✓	✓	✓	✓	✓	✓	✓

Quality Committee

Name	27/04/2017	29/06/2017	31/08/2017	26/10/2017	21/12/2017	22/02/2018
Chapman, David	✓	✓	✓	Apols	✓	✓
Collison, Kiren	✓	✓	✓	Apols	N/A	N/A
Delaney, Mike	✓	✓	✓	Apols	✓	Apols
Hedges , Diane	✓	Apols	Apols	Apols	✓	✓
Mountford, Catherine	✓	Apols	✓	✓	✓	✓
Rooney, Guy	✓	✓	✓	Apols	✓	✓
Wallace, Louise	✓	✓	✓	✓	✓	✓
Wiltshire, Sula	✓	✓	✓	✓	✓	✓

Remuneration Committee

Name	04/2017	11/07/2017	21/07/2017	10/10/2017	14/11/2017	21/11/2017	19/12/2017
Collison, Kiren	Apols	Apols	Apols	Apols	✓	Apols	Apols
Dickinson, Roger	✓	✓	✓	✓	✓	✓	✓
Delaney, Mike	✓	✓	✓	Apols	Apols	✓	✓
McManners, Joe	Apols	✓	Apols	✓	✓	✓	Apols
Smith, Duncan	✓	✓	✓	✓	✓	✓	✓
Wallace, Louise	✓	✓	✓	✓	✓	✓	✓

Oxfordshire Primary Care Commissioning Committee

Name	02/05/2017	25/07/2017	05/09/2017	07/11/2017	02/01/2018	06/03/2018
Collison, Kiren				✓	✓	✓
Dandridge, Julie	✓	✓	✓	✓	✓	✓
Dickinson, Roger	✓	✓	✓	✓	✓	✓
Hedges, Diane	✓	✓	✓	Apols	Apols	Apols
Hope, Ginny	✓	Apols	✓	✓	✓	Apols
McManners, Joe	✓	Apols	Apols	Apols	N/A	N/A
Meenu, Paul	Apols	✓	✓	Apols	✓	✓
Mountford, Catherine	✓	✓	✓	✓	✓	✓
Patten, Louise	N/A	N/A	N/A	N/A	✓	Apols
Smith, David	✓	✓	Apols	✓	N/A	N/A
Smith, Duncan	✓	✓	Apols	✓	✓	✓
Patten, Louise	N/A	N/A	N/A	N/A	✓	Apols

Entity name:	NHS Oxfordshire Clinical Commissioning Group
This year	2017-18
Last year	2016-17
This year ended	31-March-2018
Last year ended	31-March-2017
This year commencing:	01-April-2017
Last year commencing:	01-April-2016

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

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	2	(1,635)	(2,394)
Other operating income	2	(1,391)	(1,253)
Total operating income		**(3,026)**	(3,647)
Staff costs	4	6,275	6,443
Purchase of goods and services	5	861,920	819,873
Depreciation and impairment charges	5	273	376
Provision expense	5	1,039	329
Other operating expenditure	5	1,428	1,455
Total operating expenditure		**870,935**	828,476
Net Operating Expenditure		**867,909**	824,829
Total Net Expenditure for the year		**867,909**	824,829
Comprehensive Expenditure for the year ended 31 March 2018		**867,909**	824,829

The notes on pages 95 to 118 form part of this statement

Statement of Financial Position as at 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Non-current assets:			
Property, plant and equipment	8	759	962
Total non-current assets		759	962
Current assets:			
Trade and other receivables	9	9,556	17,844
Cash and cash equivalents	10	118	0
Total current assets		**9,674**	17,844
Total current assets		**9,674**	17,844
Total assets		**10,433**	18,806
Current liabilities			
Trade and other payables	12	(57,851)	(57,078)
Borrowings	13	0	(924)
Provisions	14	(1,629)	(728)
Total current liabilities		**(59,480)**	(58,730)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(49,047)**	(39,924)
Non-current liabilities			
Total non-current liabilities		**0**	0
Assets less Liabilities		**(49,047)**	(39,924)
Financed by Taxpayers' Equity			
General fund		(49,047)	(39,924)
Total taxpayers' equity:		**(49,047)**	(39,924)

The notes on pages 95 to 118 form part of this statement

The financial statements on pages 91 to 94 were approved by the Board on 24th May 2018 and signed on its behalf by:

Accountable Officer
Louise Patten

Director of Finance
Gareth Kenworthy

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

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18				
Balance at 01 April 2017	**(39,924)**	0	0	**(39,924)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(39,924)**	**0**	**0**	**(39,924)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating expenditure for the financial year	(867,909)			(867,909)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(867,909)**	**0**	**0**	**(867,909)**
Net funding	858,786	0	0	858,786
Balance at 31 March 2018	**(49,047)**	**0**	**0**	**(49,047)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17				
Balance at 01 April 2016	(30,558)	0	0	(30,558)
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	0
Adjusted NHS Clinical Commissioning Group balance at 31 March 2017	(30,558)	0	0	(30,558)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating costs for the financial year	(824,829)			(824,829)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	(824,829)	0	0	(824,829)
Net funding	815,463	0	0	815,463
Balance at 31 March 2017	(39,924)	0	0	(39,924)

The notes on pages 95 to 118 form part of this statement

Statement of Cash Flows for the year ended 31 March 2018

	Note	**2017-18 £'000**	2016-17 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(867,909)	(824,829)
Depreciation and amortisation	5	273	328
Impairments and reversals	5	0	48
(Increase)/decrease in trade & other receivables	9	8,288	(8,105)
Increase/(decrease) in trade & other payables	12	647	16,658
Provisions utilised	14	(138)	0
Increase/(decrease) in provisions	14	1,039	329
Net Cash Inflow (Outflow) from Operating Activities		**(857,800)**	(815,571)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		57	(495)
Net Cash Inflow (Outflow) from Investing Activities		**57**	(495)
Net Cash Inflow (Outflow) before Financing		**(857,743)**	(816,066)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		858,786	815,463
Net Cash Inflow (Outflow) from Financing Activities		**858,786**	815,463
Net Increase (Decrease) in Cash & Cash Equivalents	10	**1,043**	(603)
Cash & Cash Equivalents at the Beginning of the Financial Year		**(925)**	(322)
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**118**	(925)

The notes on pages 95 to 118 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 2017-18 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis.

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

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

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 Pooled Budgets

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 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.
If the clinical commissioning group is in a “jointly controlled operation”, the clinical commissioning group recognises:

- The assets the clinical commissioning group controls;
- The liabilities the clinical commissioning group incurs;
- The expenses the clinical commissioning group incurs; and,
- The clinical commissioning group’s share of the income from the pooled budget activities.

If the clinical commissioning group is involved in a “jointly controlled assets” arrangement, in addition to the above, the clinical commissioning group recognises:

- The clinical commissioning group’s share of the jointly controlled assets (classified according to the nature of the assets);
- The clinical commissioning group’s share of any liabilities incurred jointly; and,
- The clinical commissioning group’s share of the expenses jointly incurred.

1.4 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.4.1 *Critical Judgements in Applying Accounting Policies*

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

- 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 35 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 IAS 18, in the following circumstances: contributions from Oxfordshire County Council to the Mental Health joint pool hosted by Oxfordshire Clinical Commissioning Group and receipts from the Department of Health for research performed by Oxford University. The receipts from these transactions and the associated expenditure has not been included in revenue or expenditure (see Notes 2 and 5).

1.4.2 Key Sources of Estimation Uncertainty

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

Notes to the financial statements

· 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 CCGs main provision (£1.7m) as at 31 March 2018 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 and include an estimate of partially completed spells. A maternity pathway prepayment has also been accounted for. For both partially completed spells and maternity prepayments reliance is placed on estimates of value provided by acute service providers. Expenditure related to spells which are partially completed at the year end are apportioned across years on a pro rata basis.The value of spells at the year end that relate to the current year is accrued on the basis of a calculation by the acute service provider based on a point in time deemed representative of the year end actual value. Similarly expenditure on the maternity pathway is apportioned across years and expenditure deemed to relate to the following year is disclosed as a prepayment. Actual results may differ from those calculated but the estimates have not shown material variation year on year to date.

1.5 **Revenue**

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.6 **Employee Benefits**

1.6.1 **Short-term Employee Benefits**

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

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

1.6.2 **Retirement Benefit Costs**

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

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

1.7 **Other Expenses**

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

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

1.8 **Property, Plant & Equipment**

1.8.1 **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.

Notes to the financial statements

1.8.2 **Valuation**

All property, plant and equipment are 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.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value in existing use.

1.8.3 **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.

1.9 **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 their estimated useful lives.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its tangible 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.

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.

1.10 **Leases**

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

1.10.1 **The Clinical Commissioning Group as Lessee**

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

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

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

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

1.11 **Cash & Cash Equivalents**

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

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

1.12 **Provisions**

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

Notes to the financial statements

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

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

1.13 **Clinical Negligence Costs**

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

1.14 **Non-clinical Risk Pooling**

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

1.15 **Continuing healthcare risk pooling**

In 2014-15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme, clinical commissioning groups contributed annually (until 2016-17) to a pooled fund. This fund is used to settle the claims. Note 30 reports the provision for claims arising after 31 March 2013.

1.16 **Contingencies**

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

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

1.17 **Financial Assets**

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

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

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

1.18 **Financial Liabilities**

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

1.19 **Value Added Tax**

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

1.20 **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.

Notes to the financial statements

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).

1.21 **Joint Operations**

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

1.22 **Research & Development**

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

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

The DHSC Group accounting manual does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to FREM adoption and early adoption is not therefore permitted.

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)
- IFRS 17: Insurance Contracts (application from 1 January 2021)
- IFRIC 22: Foreign Currency Transactions and Advance Consideration (application from 1 January 2018)
- IFRIC 23: Uncertainty over Income Tax Treatments (application from 1 January 2019)

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

2 Other Operating Revenue

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
Prescription fees and charges	769	0	769	661
Education, training and research	52	52	0	0
Non-patient care services to other bodies	1,583	132	1,451	2,394
Other revenue	622	133	489	592
Total other operating revenue	**3,026**	**317**	**2,709**	3,647

Contributions from Oxfordshire County Council to the Mental Health joint pool hosted by Oxfordshire Clinical Commissioning Group and receipts from the Department of Health for research performed by Oxford University have not been included in revenue in 2016-17 in accordance with IAS 18 as the CCG is deemed to be acting as an agent.

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

3 Revenue

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
From rendering of services	3,026	317	2,709	3,647
Total	**3,026**	**317**	**2,709**	3,647

4. Employee benefits and staff numbers

4.1.1 Employee benefits	**2017-18**	**Total**	
	Total £'000	**Permanent Employees £'000**	**Other £'000**
Employee Benefits			
Salaries and wages	5,090	4,854	236
Social security costs	555	555	0
Employer Contributions to NHS Pension scheme	611	611	0
Apprenticeship Levy	11	11	0
Termination benefits	8	8	0
Gross employee benefits expenditure	**6,275**	**6,039**	**236**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	**6,275**	**6,039**	**236**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**6,275**	**6,039**	**236**

4.1.1 Employee benefits	2016-17	Total	
	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	5,264	4,897	367
Social security costs	555	555	0
Employer Contributions to NHS Pension scheme	624	624	0
Gross employee benefits expenditure	6,443	6,076	367
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	6,443	6,076	367
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	6,443	6,076	367

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 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 2018, is based on valuation data as at 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

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

For 2017-18, employers' contributions of £617k were payable to the NHS Pensions Scheme (2016-17: £571k) at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014. These costs are included in the NHS pension line of note 4.1.

5. Operating expenses

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	5,573	5,239	334	5,705
Executive governing body members	702	691	11	738
Total gross employee benefits	**6,275**	**5,930**	**345**	6,443
Other costs				
Services from other CCGs and NHS England	7,118	4,636	2,482	9,341
Services from foundation trusts	548,331	0	548,331	518,243
Services from other NHS trusts	7,168	0	7,168	6,574
Services from other WGA bodies	0	0	0	(2)
Purchase of healthcare from non-NHS bodies	106,470	0	106,470	99,994
Chair and Non Executive Members	184	184	0	182
Supplies and services – clinical	2,159	0	2,159	2,067
Supplies and services – general	746	172	574	(94)
Consultancy services	1,188	1,188	0	940
Establishment	1,435	257	1,178	777
Transport	3	1	2	3
Premises	2,894	756	2,138	2,450
Impairments and reversals of receivables	0	0	0	1
Depreciation	273	273	0	328
Impairments and reversals of property, plant and equipment	0	0	0	48
Audit fees	83	83	0	26
Other non statutory audit expenditure				
· Internal audit services	0	0	0	161
· Other services	0	0	0	1
Prescribing costs	84,846	0	84,846	83,503
Pharmaceutical services	0	0	0	1
GPMS/APMS and PCTMS	99,050	103	98,947	93,648
Other professional fees excl. audit	17	17	0	0
Legal fees	132	132	0	383
Grants to Other bodies	476	0	476	500
Research and development (excluding staff costs)	769	0	769	761
Education and training	280	123	157	232
Provisions	1,039	0	1,039	329
CHC Risk Pool contributions	0	0	0	1,626
Other expenditure	0	0	0	10
Total other costs	**864,661**	**7,925**	**856,736**	822,033
Total operating expenses	**870,936**	**13,855**	**857,081**	828,476

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

Note 5 excludes expenditure funded by contributions from Oxfordshire County Council to the Mental Health joint pool hosted by Oxfordshire Clinical Commissioning 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. In accordance with IAS 18, the CCG is deemed to be acting as an agent and therefore excludes the related expenditure (and revenue) from its accounts.

The External Audit fee for 2017-18 is £69.5k exc VAT. The 2016-17 figure shown above includes the impact of accruals from the previous year.

6.1 Better Payment Practice Code

Measure of compliance	**2017-18 Number**	**2017-18 £'000**	2016-17 Number	2016-17 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	3,917	87,694	4,848	109,183
Total Non-NHS Trade Invoices paid within target	3,570	81,433	4,261	105,135
Percentage of Non-NHS Trade invoices paid within target	**91.14%**	**92.86%**	87.89%	96.29%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	4,140	559,610	4,105	520,774
Total NHS Trade Invoices Paid within target	3,889	555,961	3,890	513,257
Percentage of NHS Trade Invoices paid within target	**93.94%**	**99.35%**	94.76%	98.56%

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

	Land £'000	**Buildings £'000**	**Other £'000**	**2017-18 Total £'000**	Land £'000	Buildings £'000	Other £'000	2016-17 Total £'000
Payments recognised as an expense								
Minimum lease payments	0	2,721	(0)	**2,721**	0	1,608	(15)	1,593
Contingent rents	0	0	0	**0**	0	0	0	0
Sub-lease payments	0	0	0	**0**	0	0	0	0
Total	**0**	**2,721**	**(0)**	**2,721**	0	1,608	(15)	1,593

Whilst our arrangements with Community Health Partnerships Limited and 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. A new Heads of Terms was agreed in 2017 with NHS Property Services Limited and runs for 5 years from 30 April 2017. The minimum lease payments are shown below:

7.1.2 Future minimum lease payments

	Land £'000	**Buildings £'000**	**Other £'000**	**2017-18 Total £'000**	Land £'000	Buildings £'000	Other £'000	2016-17 Total £'000
Payable:								
No later than one year	0	403	0	**403**	0	31	0	31
Between one and five years	0	1,209	0	**1,209**	0	0	0	0
After five years	0	0	0	**0**	0	0	0	0
Total	**0**	**1,612**	**0**	**1,612**	0	31	0	31

8 Property, plant and equipment

2017-18	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2017	0	250	0	0	0	0	553	624	1,427
Additions purchased	0	0	0	0	0	0	70	0	70
Cost/Valuation at 31 March 2018	**0**	**250**	**0**	**0**	**0**	**0**	**623**	**624**	**1,497**
Depreciation 01 April 2017	0	0	0	0	0	0	262	203	465
Charged during the year	0	50	0	0	0	0	99	124	273
Depreciation at 31 March 2018	**0**	**50**	**0**	**0**	**0**	**0**	**361**	**327**	**738**
Net Book Value at 31 March 2018	**0**	**200**	**0**	**0**	**0**	**0**	**262**	**297**	**759**
Purchased	0	200	0	0	0	0	262	297	759
Total at 31 March 2018	**0**	**200**	**0**	**0**	**0**	**0**	**262**	**297**	**759**
Asset financing:									
Owned	0	0	0	0	0	0	262	297	559
Held on finance lease	0	200	0	0	0	0	0	0	200
Total at 31 March 2018	**0**	**200**	**0**	**0**	**0**	**0**	**262**	**297**	**759**

8 Property, plant and equipment cont'd

2016-17	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2016	0	0	0	0	0	0	553	593	1,146
Additions purchased	0	250	0	0	0	0	44	35	329
Impairments charged	0	0	0	0	0	0	(44)	(4)	(48)
Cost/Valuation at 31 March 2017	0	250	0	0	0	0	553	624	1,427
Depreciation at 01 April 2016	0	0	0	0	0	0	68	69	137
Charged during the year	0	0	0	0	0	0	194	134	328
Depreciation at 31 March 2017	0	0	0	0	0	0	262	203	465
Net Book Value at 31 March 2017	0	250	0	0	0	0	291	421	962
Purchased	0	250	0	0	0	0	291	421	962
Total at 31 March 2017	0	250	0	0	0	0	291	421	962
Asset financing:									
Owned	0	0	0	0	0	0	291	421	712
Held on finance lease	0	250	0	0	0	0	0	0	250
Total at 31 March 2017	0	250	0	0	0	0	291	421	962

8.1 Economic lives

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

9 Trade and other receivables	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
NHS receivables: Revenue	185	0	886	0
NHS prepayments	1,722	0	1,822	0
NHS accrued income	70	0	522	0
Non-NHS and Other WGA receivables: Revenue	267	0	1,014	0
Non-NHS and Other WGA prepayments	0	0	6,350	0
Non-NHS and Other WGA accrued income	2,295	0	625	0
Provision for the impairment of receivables	(3)	0	(3)	0
VAT	51	0	18	0
Other receivables and accruals	4,969	0	6,610	0
Total Trade & other receivables	**9,556**	**0**	17,844	0
Total current and non current	**9,556**		17,844	
Included above:				
Prepaid pensions contributions	0		0	

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

Other receivables include the Clinical Commissioning Group's share of receivables relating to the Pooled Budgets, which are hosted by Oxfordshire County Council.

9.1 Receivables past their due date but not impaired	2017-18 £'000 DH Group Bodies	2017-18 £'000 Group Bodies	2016-17 £'000 All receivables prior years
By up to three months	90	0	66
By three to six months	0	0	0
By more than six months	0	1	0
Total	**90**	**1**	66

£30k of the amount above has subsequently been recovered post the statement of financial position date.

The Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2018.

9.2 Provision for impairment of receivables	2017-18 £'000 DH Group Bodies	2017-18 £'000 Group Bodies	2016-17 £'000 All receivables prior years
Balance at 01 April 2017	(3)	0	(198)
Amounts written off during the year	0	0	0
Amounts recovered during the year	0	0	195
Balance at 31 March 2018	**(3)**	**0**	(3)

	2017-18 £'000	2016-17 £'000
Receivables are provided against at the following rates:		
NHS debt	0%	0%
Non NHS Overdue 31-60 days	25%	25%
Non NHS Overdue 61-90 days	50%	50%
Non NHS overdue greater than 90 days	100%	100%

Receivables relating to other public bodies such as Oxfordshire County Council are not usually included in the calculation of the provision for the impairment of receivables.

10 Cash and cash equivalents

	2017-18 £'000	2016-17 £'000
Balance at 01 April 2017	(925)	(322)
Net change in year	1,043	(603)
Balance at 31 March 2018	**118**	(925)
Made up of:		
Cash with the Government Banking Service	118	(0)
Cash and cash equivalents as in statement of financial position	**118**	0
Bank overdraft: Government Banking Service	0	(925)
Total bank overdrafts	**0**	(925)
Balance at 31 March 2018	**118**	(925)

The overdraft in financial year 2016-17 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 2017 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.

11 Analysis of impairments and reversals

11.1 Analysis of impairments and reversals: property, plant and equipment

	2017-18 £'000	2016-17 £'000
Impairments and reversals charged to the statement of comprehensive net expenditure		
Over-specification of assets	0	(48)
Total charged to departmental expenditure limit	**0**	(48)
Total charged to annually managed expenditure	**0**	0
Total impairments and reversals charged to the statement of comprehensive net expenditure	**0**	(48)
Impairments and Reversals charged to the revaluation reserve		
Total Impairments and reversals charged to the revaluation reserve	**0**	0
Total impairments and reversals of property, plant and equipment charged to the revaluation reserve	**0**	0
Total impairments and reversals of property, plant and equipment	**0**	(48)

11 Analysis of impairments and reversals cont'd

11.2 Analysis of impairments and reversals: totals

	2017-18 £'000	2016-17 £'000
Impairments and reversals charged to the statement of comprehensive net expenditure		
Departmental expenditure limit	0	(48)
Total impairments and reversals charged to the statement of comprehensive net expenditure	**0**	(48)
Impairments and reversals charged to the revaluation reserve	0	0
Total impairments	**0**	(48)

12 Trade and other payables	**Current 2017-18 £'000**	**Non-current 2017-18 £'000**	Current 2016-17 £'000	Non-current 2016-17 £'000
NHS payables: revenue	7,294	0	8,933	0
NHS payables: capital	0	0	0	0
NHS accruals	8,113	0	6,129	0
NHS deferred income	63	0	0	0
Non-NHS and Other WGA payables: Revenue	4,447	0	2,713	0
Non-NHS and Other WGA payables: Capital	91	0	(35)	0
Non-NHS and Other WGA accruals	23,688	0	24,635	0
Non-NHS and Other WGA deferred income	0	0	52	0
Social security costs	73	0	79	0
Tax	69	0	77	0
Other payables and accruals	14,013	0	14,495	0
Total Trade & Other Payables	**57,851**	**0**	57,078	0
Total current and non-current	**57,851**		57,078	

Other payables includes £8m outstanding payments to GP practices/other similar entities, £4.3m representing the CCGs share of the pooled budget current liabilities and £1.3m outstanding pension contributions at 31 March 2018.

13 Borrowings	**Current 2017-18 £'000**	**Non-current 2017-18 £'000**	Current 2016-17 £'000	Non-current 2016-17 £'000
Bank overdrafts:				
· Government banking service	0	0	924	0
· Commercial banks	0	0	0	0
Total overdrafts	**0**	**0**	924	0
Total Borrowings	**0**	**0**	924	0
Total current and non-current	**0**		924	

14 Provisions

	Current 2017-18 £'000	**Non-current 2017-18 £'000**	Current 2016-17 £'000	Non-current 2016-17 £'000
Continuing care	1,629	0	673	0
Other	0	0	55	0
Total	**1,629**	**0**	**728**	0
Total current and non-current	**1,629**		**728**	

	Pensions Relating to Former Directors £'000	**Pensions Relating to Other Staff £'000**	**Restructuring £'000**	**Redundancy £'000**	**Agenda for Change £'000**	**Equal Pay £'000**	**Legal Claims £'000**	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**673**	**55**	**728**
Arising during the year	0	0	0	0	0	0	0	1,039	0	1,039
Utilised during the year	0	0	0	0	0	0	0	(83)	(55)	(138)
Balance at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,629**	**0**	**1,629**
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	0	1,629	0	1,629
Balance at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,629**	**0**	**1,629**

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 2018. (31 March 2017 £0)

There are no provisions included by the NHS Litigation Authority as at 31 March 2018 in respect of clinical negligence liabilities of the clinical commissioning group (31 March 2017: £0)

The provision for Continuing Care of £1,629k reflects the Clinical Commissioning Group's share of the estimated liability to pay claims in respect of continuing care assessments, as part of its joint responsibility with Oxfordshire County Council for the Better Care Fund pooled budget.

The prior year provision for Other of £55k which reflected the Clinical Commissioning Group's share of Oxfordshire County Council's provision for the Better Care Fund pooled budget has been utilised during the year.

15 Contingencies

The Clinical Commissioning Group has a referral to treatment (RTT) backlog at its main acute provider. This was estimated by the provider at £25m for the Clinical Commissioning Group at 31 March 2017, reducing to £15m under the contract arrangements with the Trust and was disclosed as a contingent liability in 2016-17. The backlog has not significantly reduced during the year but there is no obligation to pay until the activity is actually carried out by the provider. NHS planning guidance requires the RTT waiting list to be "no higher" in March 2019 than in March 2018 and in any case capacity issues would not allow for any significant reduction in 2018-19. Plans to address the backlog will take place over the longer term and it is therefore considered to be business as usual. No contingent liability is disclosed at 31 March 2018.

16 Financial instruments

16.1 Financial risk management

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

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

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

16.1.1 Currency risk

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

16.1.2 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.

16.1.3 Credit risk

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

16.1.4 Liquidity risk

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

16 Financial instruments cont'd

16.2 Financial assets

	At 'fair value through profit and loss' 2017-18 £'000	**Loans and Receivables 2017-18 £'000**	**Available for Sale 2017-18 £'000**	**Total 2017-18 £'000**
Receivables:				
· NHS	0	256	0	256
· Non-NHS	0	2,562	0	2,562
Cash at bank and in hand	0	118	0	118
Other financial assets	0	4,968	0	4,968
Total at 31 March 2018	**0**	**7,904**	**0**	**7,904**

	At 'fair value through profit and loss' 2016-17 £'000	Loans and Receivables 2016-17 £'000	Available for Sale 2016-17 £'000	Total 2016-17 £'000
Receivables:				
· NHS	0	1,408	0	1,408
· Non-NHS	0	1,639	0	1,639
Other financial assets	0	6,610	0	6,610
Total at 31 March 2017	0	9,657	0	9,657

16.3 Financial liabilities

	At 'fair value through profit and loss' 2017-18 £'000	**Other 2017-18 £'000**	**Total 2017-18 £'000**
Payables:			
· NHS	0	15,407	15,407
· Non-NHS	0	42,239	42,239
Total at 31 March 2018	**0**	**57,646**	**57,646**

	At 'fair value through profit and loss' 2016-17 £'000	Other 2016-17 £'000	Total 2016-17 £'000
Payables:			
· NHS	0	15,062	15,062
· Non-NHS	0	41,808	41,808
Other borrowings	0	925	925
Total at 31 March 2017	0	57,795	57,795

17 Operating segments

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

18 Pooled budgets

The NHS clinical commissioning group shares of the income and expenditure handled by the pooled budgets in the financial year were:

	2017-18	2016-17
	£'000	£'000
Income	143,327	196,041
Expenditure	(143,327)	(196,689)

The Clinical Commissioning Group has pooled budget arrangements with Oxfordshire County Council. In 2017-18 the pooled budgets were restructured to ensure they included only budgets for which there was a clear benefit in being pooled and which met the strategic intentions of the pool. A number of budgets were therefore no longer included in the newly structured pools. There are now two pools with revised risk share arrangements rather than four as in the previous year. The Better Care Fund (BCF) pool includes services for Continuing Health Care (CHC) which used to be managed as the Older People and the Physical Disability pools. The Adults with Care and Support Needs (ACSN) pool includes the former Mental Health and Learning Disability pools 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. Both pools are fully risk shared with the Council, any over or under spends being split based on calculations 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 with Oxford Health NHS FT which exists as a block contract apart from the Adult Social Care element. Until 30 September 2017 the first £100k of any overspend on this contract was met by Oxford Health NHS FT. Any overspend above this level was split 50:50 between Oxford Health NHS FT and the ACSN pooled budget with any pool overspend shared in the risk share ratio agreed between the CCG and Oxfordshire County Council. From 1 October 2017 there has been no risk share on this contract with all risk being taken by Oxford Health NHS FT. 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 overspend in this area is split 50:50 between the partners. All other overspends are shared in line with the risk share ratio agreed between the CCG and Oxfordshire County Council.

18 Pooled budgets 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 areement. Any over or underspends on this pool are shared in the proportions 30% CCG: 70% OCC.

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 2018

	Total Contributions £'000
Partner Contributions	
Oxfordshire Clinical Commissioning Group	80,540
Oxfordshire CC Social & Community Services Directorate	97,980
Total Funding	178,520
Total Expenditure	178,520
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 2018 CCG £'000
CURRENT ASSETS	
Debtors - Amounts falling due within 1 year	
Other prepayments and accrued income	4,268
TOTAL CURRENT ASSETS	4,268
Creditors - Amounts falling due within 1 year	
Accruals and deferred income	(2,639)
NET CURRENT ASSETS / (LIABILITIES)	1,629
Provisions for Liabilities & Charges	(1,629)
TOTAL ASSETS EMPLOYED	0
FINANCED BY:	
TAXPAYERS EQUITY	
Reserve	0
TOTAL TAXPAYERS EQUITY	0

18 Pooled budgets 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 overspends within the Outcome Based Contract (OBC) until 30 September 2017 after which Oxford Health NHS FT assumed all risk and also a 50:50 share of over or under spends on Adult Social Care clients who fall outside this contract. All other over or under spends are shared in the proportion 15% CCG: 85% OCC.

ADULTS WITH CARE AND SUPPORT NEEDS MEMORANDUM of ACCOUNT for the year ending 31 March 2018

	Total Contributions £'000
Partner Contributions	
Oxfordshire CCG	62,787
Oxfordshire CC Social & Community Services Directorate	83,007
Total Funding	**145,794**
Total Expenditure	145,794
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 2018 CCG £'000
CURRENT ASSETS	
Debtors - Amounts falling due within 1 year	
Other prepayments and accrued income	698
Cash at bank and in hand	0
TOTAL CURRENT ASSETS	698
Creditors - Amounts falling due within 1 year	
Accruals and deferred income	(698)
NET CURRENT ASSETS / (LIABILITIES)	
Provisions for Liabilities & Charges	0
TOTAL ASSETS EMPLOYED	0
FINANCED BY:	
TAXPAYERS EQUITY	
General Fund	0
TOTAL TAXPAYERS EQUITY	0

19 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 individuals are as follows:

Related Party	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
OXFED Federation	2,173	0	36	0
Oxford University Hospitals NHS Trust	345,855	64	2,143	32
Principal Medical Limited	5,773	0	360	0
Spire Dunedin Hospital, Reading	731	0	(3)	0
Sonning Common Health Centre	1,370	0	0	0
Oxford Health NHS Foundation Trust	145,249	107	2,109	0
Royal Berkshire Hospital	20,937	32	0	0
Eynsham Medical Group	2,520	0	1	0

19 Related party transactions cont'd

Related parties disclosed by Senior Managers of Oxfordshire CCG

Name	Title	Relationship	Related Party
Dr Julie Anderson - (Left 30 April 17)	Locality Clinical Director	Director	Berinsfield Pharmacy
		Salaried GP	Berinsfield Health Centre
		Practice is a member	Practice is member of Abingdon Federation
Dr Stephen Attwood	Locality Clinical Director	Partner and part owner	Bicester Health Centre
		Practice is a member	ONEMED GP Federation
		Practice Shareholder	Principal Medical Limited
Dr Andrew Burnett (Left 30 April 2017)	Locality Clinical Director	Partner and part owner	Sonning Common Health Centre
		Practice is a member	SEOX Federation
		Private clinic	Spire Dunedin Hospital, Reading
		Sessional Work ended 01.02.17	Oxford Health NHS Foundation Trust
		GP Sessional Work	Oxford Out of Hours GP Service (OHFT)
		Wife and Daughter employees	Royal Berkshire Hospital
Dr Ed Capo-Bianco (joined 1 May 2017)	Locality 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
Dr Miles Carter	Locality Clinical Director	Director / Owner and Shareholder	QOF Masters Limited
		Director and Shareholder	Hanborough Medical Services
		Practice Shareholder	Principal Medical Limited
		Practice is a member	WestMed Federation
		Wife Consultant Radiologist	Oxford University Hospitals NHS FT
		Partner	Eynsham Medical Group
Dr David Chapman	Locality Clinical Director	Partner and part owner	Hollow Way Medical Centre
		Secondary Care Specialist Doctor	Southern Health Foundation NHS Trust
		Practice is a member	OXFED Federation
		Wife Advisor Manager	Oxford Citizents Advice Bureau
		Practice Partner	OXFED Federation
Dr Kiren Collison (joined 1 December 2017)	Clinical Chair	Sessional GP	
		Registered to work out of hours	
		Partner employee	Oxford University Hospitals NHS Foundation Trust
		Clinical Lead for Prime Ministers Challenge F	Witney Neighbourhood Hub
		Urgent Access Ugbs Clinical Lead	Principal Medical Limited
Dr Jonathan Crawshaw (joined 1 May 2017)	Locality Clinical Director	GP Partner	Berinsfield Health Centre
		Practice member	Abingdon Federation
		Practice Shareholder	Principal Medical Limited
		Wife employee	University Hospitals Birmingham NHS Foundation Trust
Mike Delaney (left 30 September 17)	Lay Member	Director & Shareholder	MFD Partners International
Heidi Devenish (joined 1 January 2018)	Practice Manager Representative	Business Practice Manager	Summertown Health Centre
		Husband Deputy Chief Pharmacist	Oxford University Hospitals NHS Foundation Trust
Roger Dickinson	Lay Member Lead for Governance and Vice Chair	Non Executive Director / Trustee	Institute of Food Research
		Associate	Dudley Smith Limited
Diane Hedges	Chief Operating Officer and Deputy Chief Executive	Director	Diane Hedges Ltd
Gareth Kenworthy	Director of Finance	Director	Oxfordshire Infracare LIFT
		Member of the Council of Governors	Oxford University Hospitals NHS Foundation Trust
Stuart MacFarlane (Left 30 Nov 17)	Practice Manager Representative	Partner	Bury Knowle Health Centre
		Partner	Wood Farm Medical Centre
		Member	Practice is a member of OxFED
		Practice is a member	OXFED Federation
		Director and Shareholder	BK Health Limited
Dr Joe McManners (Left 30 Nov 17)	Clinical Chair	Partner	Manor Surgery
		Practice is a member	OXFED Federation
		Wife employee	Oxford University Hospitals NHS Foundation Trust
Dr Jonathan McWilliam	Director of Public Health (OCC)	Director at OCC	Oxfordshire Pooled Budgets
		Wife is a Director and shareholder	OMG Plc
Catherine Mountford	Director of Governance	None	None
Dr Paul Park	Locality Clinical Director and Deputy Clinical Chair	GP Partner	Hightown Surgery
		Practice Shareholder	Principal Medical Limited
		Practice is a member	NOXMed Federation
		Member of Council of Governors	Oxford University Hospitals NHS Foundation Trust
		Wife Chief Officer	Leighton Buzzard Citizens Advice Bureau
Louise Patten (joined 1 January 2017)	Chief Executive Officer	Chief Executive	Buckinghamshire CCG
		Chief Executive	Oxfordshire CCG
		Company Secretary: husband's IT consultancy business	Patten Associate
		Husband held a Global Directorship role	DHL
		Trustee Director	Chalfonts Community College Academy
		Member of the Strategic Advisory Board	Brunel Business School
David Smith	Chief Executive	Wife owner	Imagine Your Potential
Dr Guy Rooney	Medical Specialist Adviser	Medical Director	Great Western Hospitals NHS Foundation Trust
Duncan Smith	Lay Member	Partner	Dudley Smith Limited Management Consultants
		Associate	Bevan Brittan Ltd
		Wife Partner	Dudley Smith Limited Management Consultants
Professor Louise Wallace	Lay Member	Managing Director and Shareholder	Health Behaviour Research Limited
		Lay Member	General Dental Council Fitness to Practice Panel
		Director and Trustee	UK Public Health Register
		Professor	Open University: Psychology and Health
		Scientific Advisor	Department of Health National Institute for Health Research Health Services and Delivery Research Programme
Sula Wiltshire	Director of Quality	Member of Council of Governors	Oxford Health NHS Foundation Trust
		Daughter employee	Oxford University Hospitals NHS Foundation Trust

19 Related party transactions cont'd

Related parties disclosed by Senior Managers of Oxfordshire CCG

ABINGDON SURGERY
BAMPTON MEDICAL PRACTICE
BANBURY HEALTH CENTRE
BANBURY ROAD MEDICAL CENTRE
BARTLEMAS SURGERY
BEAUMONT STREET SURGERY
BELL SURGERY
BERINSFIELD HEALTH CENTRE
THE HEALTH CENTRE (BICESTER)
BLOXHAM & HOOK NORTON SURGERIES
BOTLEY MEDICAL CENTRE NOW MERGED WITH KENNINGTON HEALTH CENTRE
BROADSHIRES HEALTH CENTRE
BURFORD MEDICAL PRACTICE
BURY KNOWLE HEALTH CENTRE NOW MERGED WITH MARSTON MEDICAL CENTRE & RENAMED HEDENA
CHARLBURY MEDCIAL CENTRE
CHALGROVE AND WATLINGTON SURGERIES
CHIPPING NORTON HEALTH CENTRE
CHURCH STREET PRACTICE
CLIFTON HAMPDEN SURGERY
COGGES SURGERY
COWLEY ROAD PRACTICE
CROPREDY SURGERY
DIDCOT HEALTH CENTRE
DONNINGTON MEDICAL PARTNERSHIP (THE)
EYNSHAM MEDICAL CENTRE
GORING & WOODCOTE MEDICAL PRACTICE
GOSFORD HILL MEDICAL CENTRE
HART SURGERY
HIGHTOWN SURGERY
HOLLOW WAY MEDICAL CENTRE
HORSEFAIR SURGERY
ISLIP MEDICAL PRACTICE
OBSERVATORY MEDICAL PRACTICE
JERICO HEALTH CENTRE
KENNINGTON HEALTH CENTRE NOW MERGED WITH BOTLEY MEDICAL CENTRE
KEY MEDICAL PRACTICE
KING EDWARD STREET SURGERY
ALCHESTER MEDICAL GROUP
LEYS HEALTH CENTRE
LONG FURLONG MEDICAL CENTRE
LUTHER STREET MEDICAL CENTRE
MALTHOUSE SURGERY
MANOR SURGERY
MARCHAM ROAD HEALTH CENTRE
MARSTON MEDICAL CENTRE NOW MERGED WITH BURY KNOWLE HEALTH CENTRE & RENAMED HEDENA
MILL STREAM SURGERY
MONTGOMERY-HOUSE SURGERY
MORLAND HOUSE SURGERY
NETTLEBED SURGERY
NEWBURY STREET PRACTICE
NUFFIELD HEALTH CENTRE
OAK TREE HEALTH CENTRE
RYCOTE PRACTICE
SIBFORD SURGERY
SONNING COMMON HEALTH CENTRE
SOUTH OXFORD HEALTH CENTRE
ST BARTHOLOMEWS MEDICAL CENTRE
ST CLEMENTS SURGERY OXFORD
SUMMERTOWN HEALTH CENTRE
TEMPLE COWLEY HEALTH CENTRE
WALLINGFORD MEDICAL PRACTICE
WEST BAR SURGERY
WHITE HORSE MEDICAL CENTRE
WINDRUSH SURGERY BANBURY
WINDRUSH MEDICAL PRACTICE WITNEY
WOODLAND SURGERY BANBURY
WOODLANDS MEDICAL CENTRE
WOODSTOCK SURGERY
WYCHWOOD SURGERY

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 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.

20 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.

21 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:

	2017-18 Target £'000	**2017-18 Performance £'000**	**Duty Achieved?**	2016-17 Target £'000	2016-17 Performance £'000	Duty Achieved?
Expenditure not to exceed income	875,564	871,006	Yes	849,951	828,805	Yes
Capital resource use does not exceed the amount specified in Directions	70	70	Yes	344	329	Yes
Revenue resource use does not exceed the amount specified in Directions	872,468	867,909	Yes	845,960	824,829	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
Revenue administration resource use does not exceed the amount specified in Directions	14,627	13,537	Yes	14,642	14,207	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).

The 2016-17 figures for the Expenditure not to exceed income duty have been re-stated to reflect this definition.