Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Governing Body

Date of Meeting: 28 May 2015	**Paper No: 15/46**

Title of Presentation: OCCG Annual Report 2014 including Annual Governance Statement

Is this paper for	**Discussion**		**Decision**	✓	**Information**	

Purpose and Executive Summary (if paper longer than 3 pages)::
The Annual Report 2014 and Annual Governance Statement have been written in line with guidance, revised by the Integrated Governance and Audit Committee at their April meeting and audited by the external auditors, Ernst and Young. The Annual Report 2014 and Annual Governance Statement are required to be submitted with the Annual Accounts on 29 May 2015.

Financial Implications of Paper:
None

Action Required:
To approve the Annual Report 2014 and Annual Governance Statement.

NHS Outcomes Framework Domains Supported (please tick ✓)	
	Preventing People from Dying Prematurely
	Enhancing Quality of Life for People with Long Term Conditions
	Helping People to Recover from Episodes of Ill Health or Following Injury
	Ensuring that People have a Positive Experience of Care
✓	Treating and Caring for People in a Safe Environment and Protecting them from Avoidable harm

Equality Analysis completed (please tick and attach)	Yes	No	Not applicable ✓
Outcome of Equality Analysis			

Author: Catherine Mountford, Director of Governance	**Clinical Lead:** Dr Joe McManners, Chair

Oxfordshire Clinical Commissioning Group

Annual Report (draft) 2014-2015

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Member Practices Introduction

Foreword from the Clinical Chair, Dr Joe McManners

Oxfordshire Clinical Commissioning Group (OCCG) was established on 1 April 2013, as part of the reorganisation of NHS commissioning following the passage of the Health and Social Care Act 2012. OCCG is a statutory body that plans, buys and oversees health services from a range of NHS, voluntary, community and private sector providers. Clinical Commissioning Groups put clinicians, who are attuned and responsive to the health needs of the local population, at the heart of commissioning.
All GP practices in Oxfordshire are members of OCCG, and the views of the health professionals who work in these surgeries inform the OCCG's priorities. For our purposes, Oxfordshire is divided into six geographical areas known as the Localities: North, North East, Oxford City, South East, South West and West. A GP representative of each Locality sits on OCCG's Governing Body.

OCCG's second year of operation has coincided with a challenging period for everyone in the NHS. Demands on services have been going up and pressures have increased. In spite of this, healthcare professionals across the NHS in Oxfordshire have maintained high-quality services, risen to the challenges posed and continue to have a positive input to developing services.

OCCG has come through a testing year, with a restructure that was, undoubtedly, a tough challenge which our staff have risen to admirably. We now have a new Chief Executive Officer, David Smith, and a stable senior team, an excellent set of managers and reducing numbers of vacancies and interim staff. I have also appointed a deputy Clinical Chair, Dr Paul Park, North Locality Clinical Director and a GP from Hightown Surgery in Banbury, to further strengthen clinical leadership within the organisation. OCCG has also appointed new Lay members, Roger Dickinson and Duncan Smith, who have joined our Governing Body.

Executive Directors are now attending Locality meetings where possible, to ensure a two-way flow of information between GPs and the senior management team. We have also updated the flow of OCCG's corporate meetings to make sure that discussions and decisions from the Locality meetings feed into OCCG's decision-making process.

We have undergone regular assurance reviews with NHS England as part of the CCG Assurance Framework. We also did an internal review of OCCG's Constitution and are currently working with NHS England to ensure that our revised constitution meets all national requirements.

In spite of the restructure, there has been no shortage of activity and work, some of which has been successful, some has required further work, and we have learned some valuable lessons. What has been encouraging is the direction of travel towards a more consensual, 'whole system' approach, based around what is best for patients and makes more clinical sense.

Our finances have moved from a deficit position in the middle of 2014 to a small surplus. We could not have achieved this without the efforts and contribution of Oxfordshire's GP practices and colleagues across health and social care. An improved funding position for the coming year, including the recent success of our Prime Minister's Challenge Fund bid, will enable us to go further in developing and reinforcing the vital role played by primary care in our local NHS services.

Clinical input to commissioning

We have been listening to and acting on feedback from GPs and practices, individually and through Locality groups. Three of the issues which are consistently raised are musculoskeletal services (MSK), the role of District Nursing and the NHS 111 service. We are reviewing all three of these and are at different stages - service redesign, reviewing the model of care and re-procurement respectively.

Other instances where GPs and hospital and community clinicians have had a valuable input into redesigning services this year include:

- The review of bladder and bowel services; we were told that patients 'bounce around the system' and too frequently have excessive interactions with health services. The new pathway has been co-designed with patients and clinicians to reduce the number of appointments.
- Mental health;
    - OCCG listened to feedback from GPs and practices on the complex needs services and have increased resources to fill a gap left by a reduction in funding from the Department of Health. This means that there will be more money this year for psychological therapies and other services.
    - We are also delighted by the difference that moving towards paying for patient outcomes, rather than just attendances, within mental health services is making to the way our mental health service providers work together. We will continue to strengthen this and incentivise work with voluntary sector providers, including Restore, Oxfordshire Mind, Response, Elmore Community Services and Connexions Oxfordshire, who are all working as partners with Oxford Health NHS Foundation Trust (OHFT) to deliver the outcomes based contract.

Planning for the next year

OCCG has held a number of planning workshops with GPs and the feedback from these were incorporated in OCCG's Operational Plan for 2014/15. Implementing that plan and making services more efficient has improved our financial position. Initiatives such as planning for end-of-life care, providing more direct medical services to nursing homes and analysis of referrals have yielded some good results. Our plans for the future include:

- Integrating health and social care teams on a Locality basis
- More community-based Diabetic specialists
- Roll out of Dermatoscopy (skin screening) and instant specialist advice via email
- Roll out of Emergency Multidisciplinary Units (EMUs) across the county and integration of sub-acute community teams, further building on the success of Abingdon and Witney
- Development of a 'tier 2' service for Ophthalmology, which, by allowing optometrists to refer patients to an intermediate level service for further investigation, rather than directly to a Consultant Ophthalmologist, will help ensure that patients get the most appropriate treatment more quickly

- Working with A&Es/ Emergency Assessment Units (EAUs) to develop 'ambulatory care', where patients can be seen, treated and sent home where appropriate without being admitted to a bed
- Instigating a health inequalities commission to examine ways of reducing health inequalities[1]
- Working with NHS England to join up primary care commissioning, we have put a new joint commissioning board in place. This will formalise existing arrangements and provide a governance structure to enable locally sensitive and place based commissioning, putting clinicians at the heart of commissioning primary care with greater clinician engagement
- Working with our emerging four GP Federations, to support them as they test pilot schemes to improve primary care services for our patients as part of the successful Oxfordshire bid to the Prime Minister's Challenge Fund
- Continue to work with partners across the Oxfordshire health and care system to align our organisations more closely, for example by establishing strategic leadership forums enable us to transform the way in which services are provided the county and address issues that we collectively face together.

Developing GP Federations

Developing primary care has been a key priority for OCCG in the last year. To maintain the best general practice for the future we need to develop better ways of working together. There is a great deal of potential for fixing some of the problems we have in our system by improving resourcing and capacity in primary care (by increasing the number of GPs and nurses). This is why OCCG has worked with NHS England (NHSE) and put support into developing federations, and will continue to explore ways of transferring services and resources into primary care.

Across the county GPs have come together into four federations, the Abingdon Federation, the Oxford City Federation (OXFED), Principal Medical Ltd (PML) Federation and South East Oxfordshire Federation, and are working jointly to develop a number of initiatives to enhance primary care services in the county and test which pilot projects will best improve patient care and keep people out of hospital. GPs are taking the lead in this area, with OCCG there to help when required.

[1] In our five year strategy, OCCG has committed to working with statutory and voluntary sector partners to tackle health inequalities in Oxfordshire. Oxfordshire has a record of Health and Local Government working to reduce health inequalities. However significant health inequalities persist across the County. As such has instigated a multi-agency Health Inequalities Commission for Oxfordshire, to answer the question: 'what does Oxfordshire need to do over the next five years to reduce health inequalities?'

Education in Primary Care

Alongside this, OCCG are prioritising GP education and development. In 2014, OCCG received a grant from Health Education Thames Valley to fund clinical education for GPs to support our commissioning objectives. OCCG subsequently commissioned a local GP training company, GP Update to deliver a training course for all Oxfordshire GPs (including locums) covering the major areas of Cardiovascular Disease, Diabetes, Chronic Kidney Disease, Respiratory Medicine and Mental Health, also covering the latest developments relevant to primary care in Gastroenterology, Neurology, Musculoskeletal Medicine, Cancer Care, Sexual Health and common infections. As well as contributing to the continuing professional development of local GPs, the project was designed to support OCCG in meeting the objectives set out in its 5-year Strategy and 2-year Implementation Plan, with a particular focus on:

- Reducing expensive non-elective admissions
- Promoting patient self-care
- Reducing outpatient referrals and follow-up
- Rational and cost-effective prescribing

The training events were held between October 2014 and January 2015 and GPs attended from all of our practices, some practice nurses have also attended. Feedback from those who attended was extremely positive and there has been great enthusiasm for repeating the training in future years. We also had a successful start to our programme of developing clinical leadership in primary care with a cohort of GPs interested in leadership coming forward.

Oxfordshire's Health

(Source: Joint Strategic Needs Assessment, 2015)

Oxfordshire's population is growing, and growing older. In mid-2013 the population was estimated to be 666,100, having risen by about 10% since 2001. The number of people aged 65 and over was 112,400, an increase of around 28% over the same period. Oxfordshire County Council's projections see this increasing by another 23% over the next ten years.

The population changes can be attributed to increased inward migration, particularly to the urban hubs of Oxford and Banbury, and the increasing life expectancy of the existing population, particularly in the rural areas of the county. Following a rise in births over the first ten years of the century, birth rates in Oxfordshire are now expected to remain stable at 2010 levels.

Oxfordshire remains the most rural county in the South East of England. Meanwhile, its population is becoming more diverse. Between the 2001 and 2011 Census surveys the proportion of people identifying as black and ethnic minorities almost doubled, from 4.9% to 9.2% of the population.

Overall, Oxfordshire is prosperous, with a strong economy and a comparatively affluent population. In 2010 it was ranked the twelfth least deprived upper tier local authority out of 152 in England. However, there are pockets of social deprivation, with 18 local areas in the most deprived 20% nationally. These areas tend to show poorer levels of health and wellbeing across a range of indicators.

Oxfordshire's population is also relatively healthy, and the county performs better than regional and national averages on many indicators. Fewer people report being limited in their daily activities and increases in healthy life expectancy mean that people are living in good health for longer. Meanwhile, healthier behaviours are more prevalent, with higher than average levels of physical activity, fewer people overweight or obese and relatively low levels of smoking. However, poor lifestyle choices are an important source of health and wellbeing needs.

The changing population profile of the county brings with it significant implications for health and wellbeing. Pressure on services seems likely to increase, particularly where demand is more highly concentrated among older people. Some services are already seeing significant challenges in meeting demand. In addition, demand for both children's and adult's social care has been growing at an even faster rate than would be expected by population growth, suggesting that previously unmet need is coming forward. Meanwhile, because the population is increasingly diverse, needs may differ from locality to locality.

Challenges and successes of the past year

Oxfordshire Clinical Commissioning Group's mission is to work with the people of Oxfordshire to develop quality health services, fit for the future.

The past year has been one of the most challenging faced by the NHS in recent times, with the continued effects of a funding squeeze alongside increasing pressures from a population with ever more complex health needs. In Oxfordshire, where OCCG has been identified as the country's third most under-funded in 2014/15, there have been well-publicised problems in emergency care and in getting people the right care when they no longer need hospital treatment.

Yet OCCG's second year of existence has also been one of establishing the building blocks for transformation, where we have provided leadership to the local NHS in trying to tackle the causes of some of these difficult and long-term problems. We have made great strides towards integrating health and social care services, and succeeded in transforming a number of care pathways as a result of in-depth consultation with clinicians and service users.

Patient quote:

"When it comes to health, it is not so much having the same service, but achieving equal outcomes."

We end the year with some significant achievements in the area of mental health, which are starting to make a real difference to patients and point the way towards a future where health providers are paid based on patients' outcomes, rather than on them turning up for appointments.

In our financial situation, which has remained difficult, we end the year on a positive note, with a small surplus - thanks to a year of tight financial management, in contrast to the deficit forecast in the middle of 2014. In addition, we have been told that our funding position will be improved for 2015/16.

In order to help make the organisation more responsive to the needs and financial challenges of the NHS in Oxfordshire, OCCG's Governing Body also made some constitutional changes. These changes saw the appointment of a new Chief Executive, David Smith, in June 2014 and an internal restructure was undertaken which now better supports clinical commissioning.

In the course of this year the NHS in Oxfordshire has fallen short of a number of national performance targets. In each case OCCG has been providing leadership to make sure that all organisations are taking the right steps to improve performance.

For example, the four-hour A&E waiting time target of 95% has still not been reached. OCCG now leads a system resilience group chaired by OCCG's Chief Executive, which meets monthly to provide oversight of the situation in our A&Es and to tackle the many factors that contribute to it.

The highly-publicised problems with Delayed Transfers of Care (DToC) have, likewise, been the subject of detailed work by the whole system, led by OCCG. This is another difficult, many-faceted problem involving partners in social care as well as health, but our Governing Body has been working hard to take a lead in identifying and implementing a whole system plan to deliver the changes required.

One of the steps we have taken to relieve pressure on the system was to set up Emergency Multidisciplinary Units (EMUs) attached to community hospitals in Abingdon and Witney. These units, which bring together consultants, GPs and nurses who focus particularly on care for the elderly to help keep them out of hospital, have worked extremely well. We hope to further develop this area of work in the future.

Many of the problems we face require a whole-system approach to resolve them. For example, contributing factors to the problem of DToC involve almost all parts of the system, from ambulance providers to social care teams. OCCG is providing leadership in this with a number of new bodies that meet regularly including a:

- System Leadership Group – this group provides the leadership and coordination of the Health and Social Care system in Oxfordshire. It oversees the delivery of all key performance targets and drives forward the transformation of the care system in the county. It manages any crises which impact on the whole system and includes consideration of wider issues as appropriate (e.g. transport, economic development etc.). The group is also responsible for forward planning and ensuring there are appropriate links with the boards of other organisations.

- Transformation Board – this board is set up to drive forward the transformation of the health and social care system in Oxfordshire. More specifically to bring together in one place all the projects, which will deliver significant change in the health and care system and provide a place for an in-depth discussion about new models of payment in the NHS; new model of provision (as detailed in the five year forward view) and system enablers (e.g. workforce, IT, assets).

- Commissioning Board (this incorporates the Joint Committee for Primary Care) – this board has been established by agreement between OCCG, Oxfordshire County Council (OCC) and NHS England (NHSE). It is a starting point in developing closer working relationships between commissioners in Oxfordshire and in the development of primary care through joint commissioning arrangements between OCCG and NHSE.

Relationships with our key partners – OCC, OHFT and Oxford University Hospitals NHS Trust (OUHT) are hugely important to us and have continued to strengthen but we recognise that there is a lot more to do to be able to deliver transformation described above.

This year we have taken major strides forward towards the goal of an integrated health and social care system. We have recently heard that our Better Care Fund Plan, which we developed with OCC, has been approved with support. This will allow us to move forward with a raft of initiatives that will not only alleviate some of the pressures on the system but allow us to provide better care and support for frail and elderly people.

Prime Minister's Challenge Fund supports work to improve primary care

GPs in Oxfordshire have been awarded £4.9m by the Prime Minister's Challenge Fund to continue their work in developing primary care services in the county. Across Oxfordshire, GPs have come together into four federations and are working jointly to develop a number of initiatives to enhance primary care services, improve patient care and keep people out of hospital.

The funding will enable the four federations to test four pilots in the county over the next year, providing neighbourhood access hubs, home visiting teams, care navigators and an online project offering email consultations and a local health website.

New Bicester Hospital opens doors to patients

The first patients are now being cared for in the new Bicester Community Hospital, which opened its doors in December 2014. The hospital was designed with patients and their wellbeing at its core, offering 12 individual rooms – each with direct access to a central garden. New facilities include a First Aid Unit, imaging (X-ray), Physiotherapy suites, and space to deliver other therapies and Out-of-Hours care.

Work has also begun on a new healthcare facility for the people of the Henley area at Townlands Hospital. OCCG is working on a set of proposals for the services to be delivered at the hospital, which will be discussed with local people in the coming months. Given the changes proposed from the original plan for services at Townlands Hospital, OCCG has agreed with the Oxfordshire Joint Health Overview and Scrutiny Committee that we will undertake a one month consultation with the local people of Henley after the general election.

SOS bus

To help ensure that patients with minor injuries sustained on a night out received appropriate treatment faster (rather than unnecessarily attending A&E) OCCG commissioned an 'SOS bus' for Oxford city centre at the weekends.

The SOS pilot was funded using part of the £4m winter money received from the government to ease winter pressures. It was run by South Central Ambulance Service (SCAS) and the bus was loaned from St John's Ambulance.

Child health booklet

OCCG published a 36-page booklet, 'Managing your child's health', covering many of the most common issues and worries arising for parents of under-5s. The booklet was distributed free of charge to GPs, pharmacies, hospitals, health centres, children's centres and other outlets throughout the county. Also available on the OCCG's website, it offers advice on everything from teething troubles to meningitis and tips on where to go when a baby needs treatment or parents need advice. See http://www.oxfordshireccg.nhs.uk/your-health/childrens-health/

Patient quote:

"As a new mum you worry about all sorts of illnesses that your baby can get – I picked up a copy of the booklet at my son's nursery. It is great and I feel reassured that I can check it when my son is under the weather. I always check the booklet and look at the websites it recommends before picking up the phone to our GP".

New patient transport system follows public consultation

OCCG introduced new rules on non-emergency patient transport from November 2014, taking into account feedback from Oxfordshire people who responded to a public consultation. The changes were needed because of rising demand for health services and a significant increase in demand for non-emergency transport journeys over the past four years.

The aim was to ensure best use of NHS resources, while ensuring that non-emergency patient transport could continue to be provided for the most vulnerable patients in the future. The service was costing the local commissioners £3.7million even though a number of the patients who used it were able to travel by bus or car. The changes will save OCCG £800,000 which will be used to address the increase in demand from patients requiring more complex or costly transport.

Some comments received during the course of the consultation:

"An excellent service which I am grateful to be able to use without it I would be unable to get to my weekly appointment. I'm sure there are those however who could use other transport."

"I think special consideration should be given to personal circumstances i.e. older frail adults who live alone and have no family nearby."

"Some consideration has to be given to patients that live in an area with little or no public transport and where no voluntary transport facilities are available. A patient's circumstances always needs to be considered."

1,200 'hidden carers' identified in Oxfordshire

OCCG supported a Carers Oxfordshire campaign during Carers' Week 2014 (9-15 June) which successfully identified over 1,200 'hidden carers' in the county. The campaign was designed to address the issue of large numbers of people providing care without any recognition or access to the support and resources they are entitled to.

Armed Forces Covenant signed

In September 2014 OCCG showed its commitment to supporting our armed forces by signing an Armed Forces Covenant at a ceremony organised by Oxfordshire County Council. The covenant recognises the value that serving military personnel, their families and veterans bring to business and the wider local community.

‘Feeling under the weather?’

We supported NHS England’s ‘Feeling under the weather?’ winter campaign, encouraging people to seek early advice so that minor illnesses would not get worse. Along with our partners in OCC, OHFT and OUHT we spread messages to the community of Oxfordshire to ensure that people (especially those over the age of 60) and their families, friends and carers understood when, and where, they should access health services across the county.

Review of pathway for Musculoskeletal services

The involvement of patients in the redesign of services has been an increasing area of focus for OCCG. One area we have been looking at closely, with the help of a Patient Advisory Group and an engagement exercise using our ‘Talking Health’ system, is musculoskeletal (MSK) services.

OCCG is developing a commissioning strategy for an MSK service that is sustainable for the future, meets patient need, is efficient and provides a quality service for patients. To do this we have involved patients, the public and clinicians throughout the project. Phase One, which included the establishment of the Patient Advisory Group to inform the development of an Outline Business Case was highlighted as best practice by the Oxfordshire Health Overview and Scrutiny Committee (HOSC). Later phases have included filming patient stories and running a public survey which ran from November 2014 to January 2015. Following the extensive formal patient engagement throughout the MSK pathway review, OCCG will continue to engage and inform patients as we move through the formal business processes and into implementation.

Comments from patients:

“The MSK team is very supportive and have treated me with care and compassion, addressing my needs as an individual. Oxford NOC [Nuffield Orthopaedic Centre] *provides a first class service.”*

“The physiotherapist who has been treating me demonstrates excellent patient care. She has been respectful, knowledgeable and friendly throughout. It has been great to have access to such an efficient service and direct access to highly specialised professionals.”

Working with Diabetes UK on an integrated service

Together with Diabetes UK, we are working with people with diabetes to glean their views on shaping a new integrated service. This follows a period of working with diabetes specialist doctors, nurses and GPs to look at current diabetes care and identify ways of improving it, with more care provided close to the patient’s home.

‘The Big Plan’ – A Learning Disability Strategy for Oxfordshire 2015 – 2018

The current Learning Disability Commissioning Strategy has expired and a new proposed strategy and set of commissioning intentions has been developed jointly by OCC and OCCG through consultation with people with learning disabilities, their families, carers and professionals. These proposals formed the draft ‘Big Plan’ which was subject to a public consultation which concluded in February 2015.

The Big Plan, which was agreed by OCCG in March 2015, proposes a number of significant changes to the delivery of healthcare for people with learning disabilities. The strategy proposes integrating the provision of mental and physical health care for people with learning disabilities with health mainstream services so that everyone in Oxfordshire gets their physical and mental health support from the same health services – whether or not they have a learning disability.

The plan outlines that OCCG and the County should commission:

- Healthcare for people with learning disability within mainstream services and contracts
- A "reasonable adjustments" service that supports providers with advice and training on working with people with learning disability and can provide assurance that mainstream services are working effectively
- An employment and wellbeing service that helps people live productive lives and manage some of their health and social care needs more effectively.

In addition, the consultation has led to a number of specific proposed changes to the Big Plan in relation to healthcare:

- A 'Medically Complex Case Management' function will be created to ensure that those people (around 150) who need it have an integrated health service
- An integrated learning disability 'intensive support' function along similar lines to that which already happens in children's mental health services. This was originally proposed as a standalone service.

OCC and OCCG are also commissioning a countywide Dementia Support Service in late 2015, and this will incorporate a learning disability specialism for those with dementia.

What patients say about Learning Disability services in Oxfordshire:

"Most of the time I am independent, now I can do most things myself. I started living by myself and staff helped me to learn to do this. I can travel anywhere I want now"

"Independent supported living is something we want and need. Different types are important and it's good to see that is still in the Big Plan."

Serious Case Review – Operation Bullfinch

Since the abuse uncovered by Operation Bullfinch there has been widespread action across health systems to understand how such crimes could have continued over such a long period of time and why health services were not aware of the abuse.

The Serious Case Review (SCR) was published on 3 March 2015 by Oxfordshire Safeguarding Children Board (OSCB) identifying the work and actions taken by all partner organisations. This can be seen at http://www.oscb.org.uk/case-reviews/.

Following Operation Bullfinch, OCCG and other local NHS organisations have been working more closely in partnership with Thames Valley Police (TVP), OCC, the District Councils and other agencies to ensure services are coordinated in order to understand and meet the needs of our most vulnerable children.

New systems have now been set up to share information to help identify vulnerable children and possible victims of Child Sexual Exploitation (CSE) and help keep them safe. For example, the NHS provides a specialist nurse to work in the Kingfisher Team, a joint initiative between TVP, OCC and other agencies. In addition, the multi-agency safeguarding hub (MASH[2]) was established in September 2014 with the purpose of making sure that information is shared quickly and effectively across health, social care and the police, to help keep vulnerable children safe.

Importantly, health professionals that come into contact with children (including nurses and doctors in accident and emergency, paediatrics, general practice, mental health and sexual health services as well as school nurses) have undertaken specialised training in CSE screening and identification. They have been given new guidance to help identify this kind of abuse in future and are now clear about how and where to refer concerns.

OCCG will continue to work closely with all agencies to help the important sharing of information and provide expert interventions to ensure the safeguarding of our vulnerable children.

Further information is available in the Safeguarding Activity Report at OCCG's March Governing Body. See http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2015/03/Paper-15.23-Safeguarding-Update.pdf

Street Triage Scheme

A new Street Triage Scheme aimed at improving the way people with mental health problems are treated during emergencies, has been introduced. The scheme involves Mental Health Nurses accompanying Police Officers to incidents where police believe people need immediate mental health support.

As part of the scheme, Mental Health Nurses assist Police Officers on patrol and give advice to staff in police control rooms. The aim is to ensure that people get the medical attention they need as quickly as possible. The Street Triage team puts the needs of the person at the heart of the service and by working in partnership ensures that we find more appropriate care for those in crisis. The Street Triage Scheme has already contributed to a fall in section 136 detentions in police cells.

[2] MASH provides a link between universal services such as schools and GPs and statutory services such as police and social care. The work has been led by a multi-agency steering group which is chaired by the Assistant Chief Constable of Thames Valley Police. It also includes representatives from:

- Adult and Children's Social Care
- Thames Valley Police
- National Probation Service
- Oxford Health NHS Foundation Trust
- Oxfordshire Clinical Commissioning Group

Strategic Report

Our Strategic Direction and our Five-Year Plan

Our five-year strategic plan, incorporating a two-year operational plan, was published in March 2014 and sets out a clear direction for OCCG and for health and social care in Oxfordshire towards financial stability and a transformation of patient experience.

The plan was drafted incorporating feedback from staff and stakeholders, and following widespread public engagement. It aims to address the numerous pressures facing Oxfordshire's health and social care system, in particular:

- An increase in A&E attendances
- DToC and pressure on primary care
- A failure to meet national referral to treatment times

Our vision for five years' time is that the Oxfordshire Health and Social care system will:

- Be financially sustainable
- Be delivering fully integrated care, close to home, for the frail elderly and people living with a number of health conditions at once
- Have a primary care service that is driving development and delivery of this integrated care and is itself offering a broader range of services at a different scale
- Routinely enable people to live well at home and to avoid admission to hospital when this is in their best interests
- Be continuing to provide preventative care and to tackle health inequalities for patients and carers in both its urban and rural communities
- Be providing health and social care that is rated amongst the best in the country for all its citizens in terms of quality, outcomes and local satisfaction with services.

On the following page is our 'plan on a page' which summarises our objectives, the changes we need to make in order to achieve them, and how we plan to make this happen.

National Health Service Act 2006 (as amended)

Part of the National Health Service Act 2006 looks at the duty on NHS organisations. For clinical commissioning groups part of our duty under the act it to improve the quality of services commissioned; reduce health inequalities, involve the public in commissioning decisions and deliver a Health and Wellbeing Strategy.

This Annual Report illustrates how we comply with the Act. Oxfordshire has a Health and Wellbeing strategy which is a joint strategy designed to improve our health and wellbeing of local people, especially those with health problems or in difficult circumstances. OCCG is an active member of the Health and Wellbeing Board which monitors the delivery of the strategy.

OXFORDSHIRE CLINICAL COMMISSIONING GROUP PLAN ON A PAGE

BY WORKING TOGETHER, WE WILL HAVE A HEALTHIER POPULATION, WITH FEWER INEQUALITIES, AND HEALTH SERVICES THAT ARE HIGH QUALITY, COST EFFECTIVE AND SUSTAINABLE.

OCCG OBJECTIVES	MAKING MEASURABLE CHANGE	HOW WE WILL MAKE THIS CHANGE
1. Be financially sustainable. 2. Primary care driving development and delivery of integrated care, and offering a broader range of services at a different scale. 3. Provide preventative care and tackle health inequalities for urban and rural patients and carers. 4. Deliver fully integrated care, close to home, for the frail elderly and people with multiple physical and mental healthcare needs. 5. Enable people to live well at home and to avoid admission to hospital when this is in their best interests. 6. Be providing health and social care that is rated amongst the best in the country.	1. Compliance with all NHS financial planning rules within 3 years. 2. Reduce years of life lost from conditions amenable to healthcare by 3.2% in 5 years. 3. Meet all agreed Health and Wellbeing Board targets every year. 4. Reduce the amount of time spent avoidably in hospital by 31% in 5 years. 5. Reduce the number of people delayed on any given day from 155 to approximately 100 (depending on time of year) by October 2015. 6. Reduce A&E activity by 10 % in 5 years. 7. Increase the proportion of older people living independently at home after discharge from hospital by 8% in 2 years. 8. In the top 20% nationally for people satisfied with their experience of hospital care in 5 years. 9. Reduce outpatient activity by 4% and planned inpatient activity by 17% in 5 years. 10. Meet all NHS Constitution measures in full. 11. Increase the no. of people with mental and physical health problems having a positive experience of care by 5.2% in 5 years.	1. Deliver more efficient, better quality care in all settings. 2. Integrate commissioning and provision of all aspects of physical and mental health care. 3. Help GP practices work together to improve access and quality. 4. Increase GP capacity to deliver care to most complex patients. 5. Provide community based planned and urgent care services. 6. Provide community and home based integrated health and social care to the most complex patients, including those with mental health needs. 7. Deliver partnership programme with Councils, 3rd sector and NHS England to tackle health inequalities and their underlying causes. 8. Reduce inappropriate A&E attendances by providing viable alternatives and improving 111. 9. Reduce avoidable admissions by: a. Improving pathways for people with chronic conditions needing urgent care b. Improving support to care and nursing homes c. Improving end of life care. 10. Reduce lengths of stay by working together to improve discharge and by contracting across providers for an integrated acute pathway of care. 11. Improve access to diagnostics. 12. Ensure only appropriate outpatient referrals are made. 13. Streamline planned care pathways. 14. Reduce activity known to be of little clinical value. 15. Improve integration of physical and mental health care. 16. Improve dementia diagnosis and care.
ROBUST GOVERNANCE ARRANGEMENTS: 1. Programme Management Office in place in OCCG's Partnership programme boards for major change programmes. 2. Effective locality level patient, public and stakeholder forums. 3. Oversight by the Health and Wellbeing Board.		**PRINCIPLES UNDERPINNING DELIVERY** 1. Clinicians and Patients working together to redesign how we deliver care. 2. Reducing health inequalities by tackling the causes of poor health. 3. Commissioning Patient Centred High Quality Care. 4. Promoting integrated care through joint working. 5. Supporting individuals to manage their own health. 6. More care delivered locally.

Progress on Delivering our Five-Year Strategic Plan

Here we report progress on some of the key areas of our five-year strategy including the activities supported by our Better Care Fund plan (which supports our journey towards an integrated health and social care system), developments in primary care and a new way of contracting health care that measures the extent to which patients are made better, not just the number of times they are seen.

Integration of Health and Social Care - Better Care Fund

Our plan for use of the Better Care Fund (BCF), submitted jointly with OCC, was approved with support in January 2015. The activities we have agreed to deliver will make significant progress towards one of our strategic goal of integrating health and social care.

Healthcare services need to change from a 'sickness service' to one that is preventative of the causes of deteriorating ill health. Integrating our health and social services to provide more effective care is a crucial factor in our work to achieve this goal. The BCF builds on the successful pooled budgets that have been in place in Oxfordshire between the NHS and the County Council for many years.

The BCF will total approximately £37.5 million in Oxfordshire from 2015/16 onwards. This is not new money as it will be reallocated from within the health and social care system. However, the funding forms a key element of the OCCG's planning framework, building on our current joint working, and links closely to its operational and strategic plans. For the first time, a significant proportion of this funding is accessible by adult social care and used to protect services where it can also be demonstrated that there are benefits to health.

The activities agreed on in our BCF submission, are to:

- Expand Emergency Multidisciplinary Units (EMUs)
- Enhance Reablement Services
- Reduce DToC
- Design and deliver ambulatory emergency care pathways
- Develop integrated neighbourhood teams
- Provide care closer to home (advance care plans and proactive medical support to care homes)
- Develop Hospital at Home
- Develop the Oxfordshire Care Summary: proactive care planning
- Protect adult social care
- Implement the Care Act
- Develop carers' breaks

Mental Health

Oxfordshire has moved forward in 2014-15 to ensure that mental health is given the same importance as physical health and to improve health outcomes for people living with mental illness. OCCG has undertaken three major pieces of work which are outlined below.

Outcomes based Contracting

OCCG has now implemented a new, outcomes-based contract for mental health services. Plans are at an advanced stage to follow the same model for a new contract for older people's services.

Outcome-based Contracting has the support of NHS England, is being adopted by a growing number of CGGs and is an important part of OCCG's strategy for providing better health and social care.

Adopting Outcome-based Contracting means that the success of healthcare provision will be measured by results that matter to the patient not by numbers of patients seen. Payment to providers of the services will also be linked to the successful delivery of improved patient outcomes. Patients will have more influence over how their healthcare is delivered by helping to shape the outcomes that are included in the contracts and by making informed decisions about how their care is delivered. For mental health, these outcomes are:

- People will improve their level of functioning
- People will receive timely access to assessment and support
- Carers feel supported in their caring role
- People will maintain a role that is meaningful to them
- People continue to live in settled accommodation
- People will have less physical health problems related to their mental health.

Organisations that provide healthcare across Oxfordshire will need to work together to deliver these patient-led outcomes, and will be rewarded based on the on-going improvements in health, support and patient experience.

What patients say about Outcome-based Contracting in mental health:

"I think outcomes should lead to long-term better health and measured over a long time scale."

"What I need is the ability to access support easily as and when it is required without having to jump through hoops at a time when I feel least able to do so."

Support for people with dementia

We have improved local dementia diagnosis rates and designed a new dementia support service which will become operational during 2015-16.

Dementia diagnosis is important. It can help individuals plan their lives and commissioners and clinicians plan care. Oxfordshire has initiated a primary care-based memory assessment service that has now been rolled out to 30 local practices. This takes some pressure away from secondary

care services, and enables what can be difficult conversations about diagnosis to be led by a doctor who knows the patient and his or her family.

One challenge around dementia diagnosis is the question 'What next?' There are many questions in the short term and a need to identify ways of living well and managing needs of the patient and the family as the condition progresses, often over several years, before people require the support of specialist services. Our aim is to keep people independent and at home for as long as possible. Working with local clinicians, patients and carers and voluntary sector organisations we have developed a new dementia support service. This will involve working with people from diagnosis through the course of their illness; helping patients make plans for their lives and the care they might need and support patients and carers at times of crisis. All general practices and all patients will have a named worker who will act as a coordinator and access point to local services and to support families at difficult times. The service will be operational in 2015.

Children and Adolescent Mental Health Services

OCCG in partnership with OCC has undertaken a wide-ranging review of Children and Adolescent Mental Health Services. This piece of work had very strong engagement from children, families and professionals alike and has identified a number of challenges around access, timely diagnosis and intervention, and especially support for children at times of transition, whether from primary to secondary school or from child to adult services.

This work has led to us relaxing the hard and fast cut-offs between child and adult services - recognising that children develop at their own rate and that their 18th birthday should not represent an interruption in care. This work will continue through 2015 as we look to design services that better meet the needs of children and give them the resources and strategies that will reduce their risks of disabling mental illness as they go forward into adult life.

Developing Primary Care and Co-commissioning with NHS England

OCCG is working alongside NHSE to examine primary care commissioning plans together. A joint committee (as referenced on page 5) has been established to ensure that plans align and best suit local need.

OCCG undertook a period of engagement during the summer of 2014, inviting patients, the public and our partners to participate in a survey to gather feedback on the services people in Oxfordshire would like to see provided by general practice.

One of the key themes was the call for better information about the services available within general practice. We are therefore running an information campaign called 'Use your NHS wisely', to inform people of the variety of services and professionals available within primary care, encourage them to make better use of general practice and promote understanding of the various self-care options available.

The campaign will highlight the different roles within a GP practice, to help give people a greater understanding of what ailments they can get advice on and what treatments general practices offer. It will also highlight the impact of misuse of services.

Commissioning an Integrated Diabetes Service

Diabetes services provided by community and hospital trusts in Oxfordshire are commissioned by OCCG. Working with NHSE, we identified diabetes services as an area of healthcare where improvements could be made by taking a system-wide approach. Currently there is variation in the management of diabetes in primary care, low uptake of patient education, high rates of complications for patients, variability of discharge from secondary care, duplication of review and variability in referrals to secondary care.

The way in which diabetes services are currently provided contributes to this variation in care. There are also a small number of patients (10%) consuming a significant amount of diabetes services and budget (82%).

OCCG has established a Clinical Advisory Group (CAG) to review services and develop an outline business case. The CAG consists of representatives of all key providers of diabetes services in the county and a member of Diabetes UK, to represent the views of patients. It is important to note that Diabetes UK has conducted significant amounts of research with patients with diabetes and has run two local engagement events attended by over 100 members of the public.

OCCG has therefore committed to designing and commissioning a single, integrated diabetes service with the following objectives:

- Increased patient self-care
- Improved quality of primary care
- Improved glycaemic control in the short term
- Reduced unscheduled care
- Reduced complications in the long term
- Shorter stays in hospital.

OCCG is currently consulting with its member practices as to the way services could be improved in order to develop a new model of care for diabetes which would be commissioned from 2016/17.

Developing Outcomes based Contracts for Older People

Significant work has been undertaken around developing Outcomes based Contracting for older people's services. In a similar process to the mental health outcomes based contracting, this new approach to commissioning services for older people will bring together a number of key services into one contract that builds the care around the needs of the patient.

The two lead providers of older people's services in the county have come together to form an alliance. Together, OHFT and OUHT have met the criteria to be designated the Most Capable Provider of services for older people in Oxfordshire. This decision is subject to being able to agree a mutually acceptable contract. Once negotiations are complete, they will receive financial incentives when they deliver measurable outcomes for patients as part of a five-year contract.

The benefits of the new contract will mean that there is

- More freedom for providers to work with patients to design services that suit their needs, rather than just satisfying the demands of a contract specification

- Greater levels of recovery and well-being that increase both the individual's ability to manage their illness, and the resilience of the health and social care system to cope with the increasing demand for older people's services in Oxfordshire over the coming years with a growing elderly population

Performance against National and Local Targets

OCCG has a commitment to the Vision, Mission and Values as defined in our constitution.

Vision:

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

Mission:

We will work with the people of Oxfordshire to develop quality health services, fit for the future. Through clinical leadership we will:

Achieve good health outcomes for us all within the money available

Balance the needs of you as individuals with the needs of the whole county

"The NHS belongs to the people" (The NHS Constitution)

It has been a year of significant pressure on the NHS in all areas and in several well publicised areas, including A&E waiting times and delays in getting people discharged from hospital. As commissioners of healthcare for the people of Oxfordshire, OCCG is committed to working with providers and other partners to identify the reasons for this and to making sure they are addressed.

This section explains some of the areas where we are not doing as well as we need to and spells out what we are doing to find solutions.

In some areas, cancer waiting times are one example, we can show that the work we have been doing has made a difference and that targets are now being met or performance is on an upward trajectory. There are also some areas, however, such as A&E and DToC, which remain problematic despite proactive leadership and system-wide efforts to solve them. These remain areas of highest priority for OCCG.

Assurance Framework 2014/15: NHS Constitution Indicators

Category	Indicator	Reporting period	OCCG Value	England	RAG Criteria
Section 1 - NHS Constitution Indicators					
Referral to Treatment waiting times for non-urgent consultant led treatment	Admitted patients to start treatment within a maximum of 18 weeks from referral	Mar-15	87.53%	86.96%	Green: >=90% Red: <90%
	Non-Admitted patients to start treatment within a maximum of 18 weeks from referral	Mar-15	95.71%	94.70%	Green: >=95% Red: <95%
	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks	Mar-15	93.95%	93.05%	Green: >=92% Red: <92%
	Numbers of patients waiting more than 52 weeks	Mar-15	4	779	Green: 0, Red: > 0
Cancer Waiting Times	Maximum two week wait for first oupatient appointment for patients referred urgently with suspected cancer by a GP.	Mar-15	97.27%	94.74%	Green: >=93% Red: <93%
	Maximum two week wait for first oupatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	Mar-15	95.71%	94.94%	
	Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers	Mar-15	97.84%	97.70%	Green: >=96% Red: <96%
	Maximum 31 day wait for subsequent treatment where that treatment is surgery.	Mar-15	100.00%	95.76%	Green: >=94% Red: <94%
	Maximum 31 day wait for subsequent treatment where the treatment is an anti-cancer drug regimen.	Mar-15	100.00%	99.63%	Green: >=98% Red: <98%
	Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy.	Mar-15	99.07%	97.75%	Green: >=94% Red: <94%
	Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer	Mar-15	85.14%	83.63%	Green: >=85% Red: <85%
	Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers.	Mar-15	95.45%	93.56%	Green: >=90% Red: <90%
	Maximum 62 day wait for first definitive treatment following a consultants decision to upgrade the priority of the patient (all cancers)	Mar-15	60.00%	89.33%	No operational standard

Category	Indicator	Reporting period	OCCG Value	England	RAG Criteria
Diagnostic test waiting times	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	Mar-15	0.23%	1.51%	Green: <=1%, Red: >1%
A&E Waits	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	Apr-15	N/A	93.31%	Green: >=95% Red: <95%
Category A Ambulance Calls	Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	Mar-15	71.43%	73.41%	Green: >=75% Red: <75%
	Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	Mar-15	72.31%	69.58%	
	Category A calls resulting in an emergency response arriving within 19 minutes	Mar-15	92.94%	94.12%	Green: >=95% Red: <95%
Mixed Sex Accommodation Breaches	Breaches of same sex accommodation	Mar-15	5	273	Green: 0, Red: > 0
			0.3	0.2	Breach Rate (per 1000 FCEs)
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.	Q3 2014-15	N/A	6.30%	No operational standard
Mental Health	Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA	Q4 2014-15	98.57%	97.21%	Green: >=95% Red: <95%

Emergency Pressures

Emergency and urgent care services in Oxfordshire, in common with many parts of the NHS, have been under significant pressure in the winter of 2014-2015. At the time of publication of this annual report, the problems remain, particularly with regard to the national target of seeing 95% of A&E patients within four hours.

The most recent figures on A&E performance against the 95% four hour wait target (for a complete three month period - Quarter 3) show a figure of 91.1%, which was a deterioration compared with Quarter 2 (93.0%). The Quarter 4 performance is 85.42%. OCCG's governing body remains focused on working with providers to ensure that this target, which is an NHS Constitution commitment, is met.

The problems have persisted in spite of an injection of extra resources (£4m), which were invested in a range of initiatives to provide more capacity and staff during the winter period.

We also launched a major public awareness campaign, with advertising billboards on buses and an online campaign via popular websites and social media, to encourage people to access the appropriate service for their condition.

While the situation remains concerning, this year has seen each partner organisation making individual improvements in systems and processes. We have also seen a marked improvement in the way in which all parts of the system are working together to tackle the pressures. However, we have not yet seen these translate into an improvement in performance against the A&E four-hour target or a reduction in delayed transfers of care. Our plans for 2015/16 show a commitment to deliver the A&E four-hour target from July 2015 and to reduce Delayed Transfers of Care (DToC) by 50% this year.

Delayed Transfers of Care

For some years Oxfordshire has experienced an unprecedented number of individuals who have become delayed in their transfer of care following admission to hospital. There are a variety of factors which can become a barrier to discharge including: inadequate capacity in community services to meet the demand for domiciliary and integrated health services closer to home; access to specialist rehabilitation in the community; and housing alterations and adaptations.

Having people unnecessarily delayed in their care is not good for patients, neither is it good for the smooth running of emergency and urgent care services, as it reduces the beds available for people who urgently require hospital-based care, and can manifest as increasing waiting times in A&E departments. Hence all Oxfordshire health and social care organisations have collaborated on a system- wide plan to reduce DToC, known as 'The Oxfordshire DToC Plan'.

This plan has an ambition to reduce DToC numbers by 50%, and centres on improving both the experience of patients, and system efficiency when an individual is ready to be discharged from acute hospital care.

The primary considerations are:

- **Choice** - supporting patients and their families at the point of transferring from hospital to home or another place of care.
- **Reablement** - offering reablement to patients who can benefit, thus improving their confidence and capability and making them less likely to need long-term care.
- **Assessment** - ensuring that all patients' needs are assessed in a way that is person-centred, appropriate and timely, involving their families and carers where appropriate.
- **Using non-acute NHS beds** - when a patient is medically stable but still needs to be looked after in hospital, using non-acute beds (eg in community hospitals) to help them regain optimal levels of functioning after a stroke, trauma or other medical condition.
- **Long-term care packages** - enabling people whose mobility or other functions have been reduced to stay at home as long as possible.
- **Residential Care and Nursing Homes** - when people need residential care, making sure that this promotes individual self-determination and that care settings are responsive to the changing physical and psychological needs of the individual.
- **Housing** - identifying an individual's housing needs at the earliest opportunity and finding a solution to any problems, preventing the patient from deteriorating and needing to go back into hospital or care home - or being unable to be discharged in the first place.

Since rolling out the plan from January 2015, the system has seen a month on month sustainable reduction in DToC by 20% which continues to gain pace and momentum towards our goal**.** Significant progress has been made in:

- **Improving access to community hospital provision:** This is as a result of earlier and improved communication and administration, between the clinical and social work teams in the John Radcliffe and the Horton General Hospitals, and clinical staff managing the community beds.
- **Speeding up assessments for NHS continuing healthcare:** This is as a result of improving the nursing assessment process, and using a 'discharge to assess' process which recognises that assessments do not have to take place in an acute hospital bed. Patients can be discharged and then their assessment can be completed in a care/nursing home or in their own home, depending on their level of dependency and need.
- **Reducing waits for a care/nursing home placement:** This has been achieved through improved market management of the independent care home sector and improvements when packages of care require 'restarting' following an individual's stay in hospital.
- **Reducing referral waits for reablement:** This service provides additional health and social care support to people in their own homes and is an important means of reducing dependence on long term domiciliary care and/or care home provision.

More challenging issues facing Oxfordshire are management of 'choice' and 'out of county' patients.

The 'choice' goal involves reducing the impact on the system of patients who are fit to be discharged from acute hospital care, where suitable onward care arrangements have been identified but rejected by the patient and/or their relatives. This includes individuals whose future needs will be funded by the State, as well as those sourcing their own care independently. The system has recently revised the joint 'choice' policy to ensure that 'choice patients' are given the right support, at the right time to speed up onward care arrangements.

'Out of county' delays can account for up to 15% to 20% of DToCs, and this occurs when a patient's permanent residence is outside of Oxfordshire, and they need to return closer to home for the next stage of their care outside of an acute hospital environment. A new joint protocol is currently underway to streamline the discharge process and improve communication between Oxfordshire and 'out of county' health and social care services.

The early signs are that our DToC Plan is making steady and sustainable progress, and we are confident that we will achieve our 50% reduction goal by the end of the year.

Waiting times

The latter part of 2014-2015 has seen a significant improvement in OCCG's performance on waiting times in general and also on the specific targets that relate to patients diagnosed with cancer.

Time from referral to treatment has improved over the year. The 18-week target for patients starting treatment was met by OUHT for the majority of 2014/15, and we have seen a recent, rapid fall in the number of patients currently waiting more than 52 weeks. We are expecting this to drop to zero patients by early in 2015/16.

Two of the three main cancer waiting time targets have been achieved; the target of people being seen by a specialist within two weeks of an urgent GP referral for suspected cancer and waiting no longer than one month (31 days) from an urgent GP referral to the first definitive treatment. The two month (62 days) of people receiving their first treatment from an urgent GP referral has not been met. We are expecting this to be met by June 2015.

Quote from a patient with a cancer diagnosis, treated at the John Radcliffe Hospital, Churchill Hospital and Nuffield Orthopaedic Hospital.

"In every department, all the staff, receptionists, radiographers, nurses and doctors were everything one could wish for. I was treated extremely well with courtesy and efficiency and given every chance to ask questions. I can think of no aspect of my treatment which, overall, has lasted over six months which could have been improved upon."

We are currently undertaking a number of pieces of work to improve the way health services work, all of which have benefited from the involvement of patients and the public. These include musculoskeletal, ophthalmology, ear, nose and throat and bladder and bowel services. These will be implemented in the following few months.

Finance

Our total funding for the financial year 2014/15 was £648.9m, of which £632.7m was allocated for healthcare programme costs and £16.2m for running costs of OCCG. In setting our financial plans at the start of the year we had anticipated at deficit of £1.0m, however, by year end we are able to report a modest surplus of £1.5m. This improvement over the course of the year came from the receipt of additional funding (for the NHS costs of overseas visitors), from a reduction in expected costs (PCT legacy continuing healthcare claims) and from the management of financial risk within our contingency.

The table below summarises OCCG's financial performance by our summary level areas of expenditure at the year-end (March 2015).

	Annual Budget £'000	Budget ytd M12 £'000	Actual ytd M12 £'000	Variance M12 £'000	FOT £'000	Variance £'000
Acute	356,378	356,378	360,399	4,020	359,256	2,878
Community Health	62,520	62,520	63,821	1,301	63,020	500
Continuing Care	35,436	35,436	34,877	(558)	35,551	116
Mental Health and Learning Disability	62,177	62,177	63,048	872	63,038	861
Primary care	88,735	88,735	91,993	3,258	91,161	2,426
Other	24,285	24,285	18,779	(5,505)	19,869	(4,415)
Sub Total Programme costs	**629,530**	**629,530**	**632,918**	**3,388**	**631,896**	**2,366**
Running costs	16,159	16,159	14,409	(1,750)	16,159	0
Sub Total	**645,689**	**645,689**	**647,327**	**1,638**	**648,055**	**2,366**
Contingency	4,211	4,211	0	(4,211)	(691)	(4,902)
Deficit	(1,044)	(1,044)	0	1,044	0	1,044
Total	**648,857**	**648,857**	**647,327**	**(1,530)**	**647,364**	**(1,493)**

In seeking to provide more stability in our financial performance for 2014/15, we agreed a change to the structure of our contract with our main acute provider, OUHT, to reflect the pressures that demand places on our funding. Under the agreement, there was a new financial risk-sharing arrangement between the two organisations. This was designed to foster a mutual obligation for both partners to work closely to ensure that demand and costs could be managed safely for patients and our organisations. The main pressure on the acute budget, reported throughout the year, was the increased demand for what are termed high cost drugs and devices which were not a part of the risk sharing arrangement. Other significant budget pressures for us were prescribing costs in primary care and the Learning Disability pooled budget.

While contractual arrangements can be used to manage some of the financial risk of demand for healthcare services, a key priority in ensuring that services remain sustainable for the future is to monitor and manage demand within the available resources.

The pattern of that demand over the past year has been as follows. In Urgent care services, there has been:

- A small reduction in the volume of calls to the local NHS 111 service (-0.28%),
- A 6% increase in the number of 999 calls; but only a 2% increase in the number of calls resulting to a vehicle and crew dispatch. This difference is taken to be a result of South Central Ambulance Service (SCAS) efforts to handle more calls as what is described as "Hear and Treat" i.e. handled without the need for a paramedic/ambulance dispatch. This category shows a 47% increase year on year. The overall activity level is approximately 1% above our contract plan for the period.
- A 3.5% increase in the volume of A&E activity (this equates to an extra 10 attendances per day for OUHT)
- The growth in emergency (Non-elective) admission to a hospital has been 4.1% to date (April to January)
- There has also been a 16% increase in hospital at home activity in community services, aimed at treating people closer to home and avoiding unnecessary admission to the acute hospital.
- A 10% increase in the number of non-elective admissions that then become delayed on discharge and an increase in the average number of people delayed on discharge from 140 up to 162 delays per week at the end of the financial year.

For planned care or elective services, there has been some significant growth in outpatient activity. A significant element of this relates to the concerted effort in year to improve waiting times for elective treatment, either funded locally or nationally. Outpatient first appointments have grown by 4.7% and follow up appointments have grown by 5.9%

For the financial year 2015/16 we are receiving a £41m increase to our funding, which will help meet the challenges caused by increasing demand and an ageing population. The increase in funding will bring us closer to our target funding allocation (7.2% below rather than 10% in 2013/14). NHS England aims to bring all CCGs to within 5% of their target funding by 2016/17.

This significant increase in our funding for 2015/16 will not remove the need for us to identify and implement initiatives that improve the efficiency and value for money of our healthcare services. As a result, we have identified a savings plan of £11.4m for 2015/16.

In planned care, we will seek to make savings and quality improvements through the redesign and implementation of new patient pathways for priority specialties such as musculoskeletal and ophthalmology services. In Urgent and Planned Care, our focus remains on preventing the escalation of people's health needs and providing effective care alternatives to A&E and emergency hospital admissions. The goal is to reduce unnecessary hospital admissions, improve care for patients and ensure that costs are managed to an affordable level.

Through 2014/15 and on into 2015/16 we will continue to embed our approach to programme and project management within OCCG.

The key risk for OCCG moving forward into 2015/16 remains the same as it is for NHS organisations across the country, to address the increasing demand for NHS and hospital services.

The financial accounts have been prepared on the going concern basis despite the issue of a report to the Secretary of State for Health under Section 19 of the Audit Commission Act 1998 for the anticipated breach of financial duties. For more detail please refer to page XX.

Review of OCCG's Constitution

During 2014/15 our Vice-Chair (lead for Governance) led an internal review of OCCG's Constitution to ensure that:

- It serves the requirements of the members
- All parties understand their powers and obligations
- No activities 'fall between stools'
- All activities are subject to oversight
- Oversight is timely and appropriate
- Decision-making is faster
- The time burden on clinical and lay participants is reduced
- Managers are freed to focus their time on operational matters

We continue to work with NHS England to ensure that our revised constitution meets all national requirements.

Following the review of the feedback from the stakeholder survey OCCG has:

- Revised its overall approach to system working and established a System Leadership Group, Transformation board and Oxfordshire Commissioning Board; These have been well received by partner organisations
- Implemented a new organisational structure
- Instituted a single, simplified briefing system for member practices
- Fully aligned quality monitoring processes with the contract management mechanism to make it more effective

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 Governing Body are detailed in the NHS Oxfordshire Clinical Commissioning Group Constitution comprising scheme of delegation, standing orders, prime financial policies, roles and responsibilities and locality constitutions.

The Membership Body is represented on the Governing Body through the Locality Clinical Directors who are appointed in line with the Locality Constitutions.

Through agreement of the Constitution, the Membership Body has agreed that the Governing Body will be responsible for:

- Assurance, including audit and remuneration

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

A full copy of OCCG's Constitution can be seen at http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2015/03/OCCG-Constitution-March-20151.pdf

Managing Risk

OCCG recognises that strategic risks are ongoing and that risk management is an integral part of good management practice and so is committed to ensuring risk management is integrated into all aspects of OCCG work at all levels. Therefore, risk management is an explicit process in every activity OCCG and its employees take part in. Further information on the risk management structure within OCCG is available in the annual Governance Statement on page 79.

The principal risks identified, with an indication of mitigating measures, are as follows:

Risk	Mitigation
There is a risk that the primary care transformation required to link in with new models of care will not be delivered leading to continued pressures on the current services and sub-optimal care for patients.	OCCG's Governing Body has approved co-commissioning with NHS England. OCCG has been successful in receiving £4.9m from the Prime Minister's Challenge Fund to develop a number of initiatives to enhance primary care services, improve patient care and keep people out of hospital. As well as developing primary care premises for three practices.
There is a risk that the range of current performance challenges will affect OCCG's ability to deliver NHS Constitution pledges and optimum care pathways, in particular A&E waiting times, Cancer waiting times, Referral to Treatment Time (RTT) in 18 weeks and Delays in Transfer of Care (DToC); this may lead to poor patient experience, reduced confidence in the NHS and incur additional financial pressure.	The System Resilience Group is overseeing recovery plans on Delayed Transfers of Care, including escalated four-week reduction and planned care recovery process, covering cancer, 52-week waits and the 18-week pathway. Weekly teleconference review of all Urgent Care actions and strengthening contractual oversight of OUHT.
There is a risk that the different organisations within the health and social care system do not work together in a co-ordinated way for the benefits of patients and the most effective and efficient use of resources.	Establishment of the System Leadership Group (SLG) to provide assurance that the system is working together. The SLG created the Transformation Board to drive forward the transformation of the health and social care system. The Commissioning Board (incorporating the Joint Committee for primary care) has been established by agreement between OCCG, Governing Body, Oxfordshire County

Risk	Mitigation
	Council (OCC) and NHS England (NHSE) in March 2015. A Single Plan and series of supporting plans will be developed by September 2015.
Significant transformational change will be required of the health and social care system in Oxfordshire over the next five years. There is a risk that this will not take place because individual organisations do not have the capacity to manage these changes or the resources to deliver them. In addition, there may be external challenges which make it more difficult to deliver those changes.	Transformation Programme and Transformation Board established March 2015. Transformation Team with seconded-in staff to be formed. Overview by the Systems Leadership Group will provide external challenge.
There is a risk that the OCCG will not identify and rectify quality issues in provider organisations, resulting in sub-optimal care to patients, poor patient experience and a lack of clinical effectiveness.	CCG are reviewing their clinical assurance framework to ensure it is fit for purpose and will identify quality issues. OCCG escalates issues of poor performance through the contract to ensure action is taken to address areas of sub optimal care.
There is a risk that demand for health and social care services exceeds (affordable) capacity in the Oxfordshire system leading to a failure of national performance requirements.	Analyse and understand root causes of demand experienced in 2014-2015 and enable the system to respond to further anticipated rises. Re-designing care pathways to manage patients' needs at the most appropriate skill level. Ensure sufficient primary care capacity to manage urgent and overflow requirements. Designing quality and safety mechanisms to assure that overcrowding is not generating inappropriate patient risk.
There is a risk that the OCCG does not (a) have and (b) use high quality business intelligence products to inform its decision making in performance management, change management and investment, which may result in sub-optimal decision making and subsequent impacts.	OCCG has an approved Business Intelligence Strategy. This now needs to be developed into a programme for delivery. The strategy has been shared with Central Southern Commissioning Support Unit (as our Business Intelligence Delivery Partner) to inform the direction of work under our contract. NHS standard contract information schedules are being reviewed through contract negotiations to get closer alignment to the strategic objectives where possible. The OCCG's Organisational Development Programme has been developed to reflect Business Intelligence requirements.
There is a risk that demands on OCCG allocation exceed the available funding. As a result if demand and cost pressures exceed funding then OCCG will fail its in-year statutory financial duties and limit its ability for future sustainability and viability, which may also impact on providers and lead to a reduction in services.	OCCG has set what are considered to be affordable financial envelopes for its contracts with providers. Contract negotiation strategies will be progressed through negotiation meetings that seek to limit the OCCG's exposure to demand/activity risk through robust demand/activity management plans (QIPP), contractual arrangements and contingency reserves.

OCCG's Executive, Governing Body and Committees regularly review our approach to risk management. The up-to-date report on our strategic and operational risks can be found in our Governing Body papers at http://www.oxfordshireccg.nhs.uk/get-involved/board-meetings/

OCCG Gender Analysis

OCCG is a significant employer with a workforce comprised of employees from a wide variety of professional groups. At the end of 2014/15 OCCG employed 111 staff, of which 76 were women and 35 men. As of 31 March 2015, the Governing Body of OCCG was made up of 6 women and 14 men. Below is a breakdown of gender analysis. Very senior managers are counted within the numbers for the Governing Body. The membership body of OCCG is made up of all 79 (as at 1 April 2015) practices within Oxfordshire; a breakdown of membership by gender is therefore not available.

	Female Headcount	**Male Headcount**	**Total**
Governing Body	6	14	20
Senior Managers	7	6	13
All other Employees	63	15	78
Total Employees	76	35	111

Equality Report

The population of Oxfordshire is very diverse and each community has different needs. It is important for OCCG to understand the diversity of our county's health needs in order to ensure health services are planned properly and providing equal quality in terms of access, experience and outcomes for everyone.

The refreshed Equality Delivery System (EDS2) is a self-assessment tool that supports the evidence base of OCCG to demonstrate compliance with the Equality Act 2010 general duty and specific duties, as well as demonstrating progress the organisation has made on equality issues. EDS2 includes the nine protected characteristics covered by the Equality Act 2010, which are:

- Age
- Disability
- Gender re-assignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race, including nationality and ethnicity
- Religion or belief
- Sex
- Sexual orientation

OCCG's Annual Equality Publication provides some of the evidence of our work to address health inequalities and promote equality during 2014-15, in line with the Equality Act 2010, Public Sector Equality Duty (PSED). The publication can be seen on our website here: http://www.oxfordshireccg.nhs.uk/about-us/equality-diversity-human-rights/2014-15-evidence-of-compliance/

OCCG has also now established an Equality and Diversity Reference Group for patients and carers. The group enables patients and carers to discuss views and raise issues associated with OCCG's Equality goals and outcomes and to share their opinions and those of others in their community on subjects related to equality in health services.

Patient quotes:

"Age or impairment shouldn't be a bar to good health treatment and people should know that they're going to be treated fairly whoever they are."

"Equality is an expectation for all public services and so I would not expect anything less."

Our ultimate aim is to integrate equalities in every stage of the commissioning cycle and to ensure that equality, diversity, and reducing health inequalities are actively promoted.

OCCG has been reviewing the Human Rights in Healthcare Programme within its equality work. The Human Rights in Healthcare Programme is designed to show that using a human rights based approach can lead to improved standards of care within healthcare. In the coming year OCCG will look at how it incorporates the programme into its work.

Sustainability Report

OCCG recognises that sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live.

A Sustainability Strategy has been approved by OCCG's Governing Body which demonstrates how we aim to contribute towards meeting the national target of a 10% reduction in NHS-wide carbon emissions by 2015, and a 34% reduction in the overall national carbon footprint by 2020, as enshrined in the Climate Change Act 2008. An Action Plan was developed focusing on three areas:

- Staff awareness
- Travel, Transport and Access
- Waste, energy and carbon reduction

All staff are made aware of the aims and objectives of the Sustainability Strategy and action plan through staff induction, green champions and the intranet. Training is being provided through Sustainability Workshops run in conjunction with the Centre for Sustainable Healthcare.

OCCG has committed to a Sustainable Development Management Plan (SDMP) that addresses the financial, environmental and social sustainability of the health care services it commissions. OCCG has the following sustainability mission statement located in our Sustainable Development Management Plan (SDMP):

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

OCCG has completed the standard reporting template from the Sustainable Development Unit; it is available on our website: http://www.oxfordshireccg.nhs.uk/about-us/

Good Corporate Citizenship model

OCCG reviews its sustainability objectives annually and monitors progress through the Good Corporate Citizen (GCC) Assessment Framework. This tool is used to benchmark progress on sustainable development, not just by measuring fuel bills or waste but by evaluating sustainability across the board based on questions around carbon reduction, travel, procurement, facilities management, workforce, buildings, models of care, community, engagement and others.

The last time we used the GCC self-assessment tool was in March 2015, scoring 5% which fell in the '*Getting started'* scoring category (partly due to having no baseline against which to compare our progress). As an organisation that acknowledges its responsibility towards creating a sustainable future, our sustainability efforts are being actively pursued and now include:

- Running awareness campaigns in collaboration with *The Centre for Sustainable healthcare* that promote the benefits of sustainability to our staff
- A nominated board level member of staff - (our Chief Financial Officer) responsible for sustainability supported by the Governance Manager

Energy, water and carbon management

The majority of the environmental and social impacts are through the services OCCG commission. OCCG is committed to reducing indirect environmental and social impacts associated with the procurement of goods and services.

OCCG does not directly pay for energy and water as the responsibility for properties within the commissioning architecture sits with NHS Property Services Ltd and this is covered in OCCG's lease.

Climate Change

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. OCCG has identified the need for the development of a plan for future climate change risks affecting our area.

Members' Report

Ensuring Quality Health Services

Ensuring high standards of healthcare for the people of Oxfordshire is at the heart of our organisation. To this end we systematically collect feedback from members of the public about their experiences of the service they have received. We also provide a feedback mechanism for GPs to share information with us on the services commissioned by OCCG.

Between June 2012 and March 2015 over 1825 pieces of feedback were reported via the Datix system for GPs. This information is triangulated with information from serious incident, patient experience and performance data to identify poor care.

Action is taken centrally by OCCGs Quality Team to address the issues identified in this way. Regular progress reports are then prepared and 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 contract levers are being applied where the change is too slow.

Some examples of the changes made as a result of the feedback received are:

- Improved access turnaround times in radiology
- Improved access to Mental Health Assessments for adults and older adults
- Improved verbal and written communication between Mental Health services and GP practices
- Reduction in the number of poor inpatient discharges relating to anticoagulation
- Improved access to appointments for Ear, Nose and Throat (ENT) services
- Improvements in waiting times at the MSK hub

There is ongoing work in a number of areas which, despite the use of contractual levers, have shown little or no sustained improvement - for example the management of test results. Other areas have shown only slow improvement, such as roll out of directly bookable services to improve access to appointments and turnaround times for outpatient letters at the OUHT. OCCG are currently negotiating the 2015/16 contract and are hoping to strengthen arrangements to encourage a more proactive approach from our providers.

OCCG works closely with the LMC to address areas where the interface between primary and secondary care causes extra workload, including the speed of sending out letters, lack of follow-up of test results and prescribing requests.

Our local NHS services continue to perform well in the 'Friends and Family' test, which assesses services based on the percentage of people likely or extremely likely to recommend them. OUHT regularly get higher than the national and Thames Valley area scores. In February 2015, for A&E 92% of people surveyed said they would recommend OUHT, as compared to all England score of 88% and a Thames Valley area score of 91%. For inpatients they scored 96% as compared to national score of 95%. This year has seen a number of changes to the 'Friends and Family' test and in January 2015 it was extended to capture feedback from GPs and NHS funded Community and Mental Health services. Full details can be seen at http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/

From April 2015 it will also be rolled out for use with ambulance services, the patient transport service, acute outpatients, day-case patients, walk-in centres, minor injury units and dental practices.

OCCG has received 34 formal complaints during 2014/15. One complaint was referred to the Ombudsman and this is awaiting their investigation. We received 346 Patient Services queries during this period.

When a serious incident (SIRI) occurs with one of our providers, they are required to report it to us. OCCG will then ensure 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. One hundred and twenty six incidents were reported to us during 2014/15. OCCG has not declared any serious incidents requiring investigation (SIRI) that required investigation. Information on how these incidents are disclosed and managed is available in OCCG's Governance Statement on page 74.

OCCG follows the Parliamentary and Health Services Ombudsman's Principles for Remedy in complaint handling. This means that we support patients and the public to make complaints, and seek to resolve issues whether or not they are submitted as formal complaints. When appropriate we facilitate a meeting between the complainant and the organisations involved in order 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 we manage apply to a number of organisations. In these cases we often conduct an 'end to end' review of the complaint. This produces a thorough understanding of the issues and enables the agencies to work together to make improvement and prevent recurrence.

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, our 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 the Local Health Resilience Partnership
- Maintain robust business continuity plans and test them
- Support NHS England South (South Central) 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 exercise and testing programmes as part of the NHS England South (South Central) assurance processes
- Provide commissioned providers with a route of escalation on a 24/7 basis if they fail to maintain their performance levels
- Respond to reasonable requests to assist and co-operate

- Support NHS England South (South Central) should any emergency require wider NHS resources to be mobilised
- Support NHS England South (South Central) to effectively mobilise all applicable providers that support primary care services should the need arise.

We are also 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 and 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 that are escalated to us by our providers and a 24/7 communications-on-call rota to deal with media and communication issues.

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

We participate regularly in Exercise Talk Talk - a communication cascade exercise that tests the flow of information between emergency responders across the health system in the Thames Valley - as well as participating in the following:

- Exercise Yambuku, November 2014 – which tested plans to deal with Ebola
- The Annual Planning Symposium – Working Together Better, January 2015.

We also took part in the response to water contamination in May 2014 and flooding in September 2014.

We certify that OCCG has incident response plans in place, which are fully compliant with the NHS Commissioning Board 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 Governing Body.

Valuing our Staff

Employee Consultation

We 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 committee for staff engagement and consultation and we have actively and successfully worked in partnership on a number of important issues affecting our staff including an organisational re-structure, the development of a staff health and wellbeing strategy and HR policy development. Policies are ratified by OCCG's Executive Committee 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.

A selection of the tools and methods developed to communicate and encourage meaningful, two-way dialogue with staff include:

- Monthly staff briefings led by the Executive Team with a question and answer session included
- Monthly staff newsletter
- Staff Surveys to drive improvement in staff experience
- Corporate website and intranet
- Staff development sessions
- Anonymous online feedback mechanism during staff consultations

Managers also hold regular one-to-one meetings with staff and the appraisal system ensures all staff work towards clearly defined personal objectives which are supported with learning, training and development opportunities detailed in individual personal development plans.

OCCG has established an Organisational Development (OD) Steering Group to oversee the implementation of our internal OD plan. A key piece of work has commenced to review OCCG's vision and values and to develop a supporting behavioural framework which will also underpin the introduction of a values based approach to appraisals. All staff will be given the opportunity to contribute to this piece of work via focus groups, 1-1s and an Appraisal Steering Group to enable maximum staff engagement.

Staff Sickness Absence

Sickness absence rates across OCCG remains comparable with the national average for CCGs with an absence rate of 2.14%.

April 2014 to March 2015	
Total whole time equivalent (WTE) available (days)	28,183.34
Total WTE days sickness	603.80
% WTE days sickness	2.14%

(See page XX for more information on employees' benefits in note to accounts page.)

Sickness absence is managed in a supportive and effective manner by OCCG managers, with professional advice and targeted support from Human Resources, 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 reinforced by the provision of HR support 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 the provision of annual flu jabs and initiatives including an interactive Health Kiosk as part of the implementation of the Staff Health & Wellbeing Strategy. The Employee Assistance Programme also promotes key theme each month and staff have access to a 24/7 helpline.

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.

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.

Health and Safety

The CCG recognises that the maintenance of a safe work place and safe working environment is critical to our continued success and accordingly, we view our responsibilities for health, safety and welfare as the upmost importance. The CCG 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.

A new Health and Safety Policy is currently being developed by the CCG and will be submitted for ratification to the Governing Body in 2015.

Countering Fraud in the NHS

The CCG has a Counter Fraud Bribery and Corruption Policy which applies to all staff, contractors and agency workers. The Local NHS County Fraud Specialist works with the CCG and managers and delivers all counter fraud work. The Audit Committee receives reports on counter fraud work undertaken at the CCG.

OCCG's Corporate Governance Structure

Our Localities

OCCG is a clinically led membership organisation made up of 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 Governing Body. 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.

North East Oxfordshire

There are 10 GP practices in the locality with a combined population of just over 78,000. The Locality Clinical Director is Dr Stephen Attwood, who is supported by Dr Will O'Gorman. The 10 practices are:

1. Bicester Health Centre
2. Exeter Surgery
3. Gosford Hill Medical Centre
4. Islip Medical Practice
5. Kidlington & Yarnton Medical Group
6. Langford Medical Practice
7. Montgomery House Surgery
8. North Bicester Surgery
9. Victoria House Surgery
10. Woodstock Surgery

North Oxfordshire

For the majority of 2014/15 there were 13 GP practices in the locality with a population of 105,963. The Locality Clinical Director is Dr Paul Park, who was supported by Dr Judith Wright as Deputy. The 13 practices are:

1. Banbury Health Centre
2. Bloxham & Hook Norton surgeries
3. Cropredy Surgery
4. Deddington Health Centre
5. Hightown Surgery
6. Horsefair Surgery
7. Sibford Surgery
8. West Bar
9. West Street Surgery
10. White House Surgery
11. Windrush Surgery
12. Woodlands Surgery - Banbury
13. Wychwood Surgery

In April 2015 West Street and White House Surgery merged to become one GP practice.

Oxford City

There are 23 GP practices in the locality with a population of nearly 200,000. The Locality Clinical Director is Dr David Chapman supported by Dr Merlin Dunlop, Dr Karen Kearley and Dr Andy Valentine. The 23 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. Bury Knowle Health Centre
8. Donnington Medical Partnership at Donnington Health Centre
9. Dr Stevens & partners at East Oxford Health Centre
10. Dr Bogdanor & partners at Jericho Health Centre
11. Dr Kearley, Chivers and Partners
12. Hollow Way Medical Centre
13. King Edward Street Surgery
14. Luther Street Medical Centre
15. Manor Surgery
16. Marston Medical Centre
17. South Oxford Health Centre
18. St Bartholomew's Medical Centre
19. St Clement's Surgery
20. Summertown Health Centre
21. Temple Cowley Health Centre
22. The Leys Health Centre
23. Wood Farm Health Centre

South East Oxfordshire

There are 10 GP practices in the locality with a population of 89,984. The Locality Clinical Director is Dr Andrew Burnett, who is supported by Dr Amar Latif. The 10 practices are:

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

South West Oxfordshire

During 2014/15 there are 14 GP practices in the locality with a population of around 140,000. The locality Clinical Director is Dr Julie Anderson, who is supported by Dr Gavin Bartholomew. The 14 practices are:

1. Abingdon Surgery
2. Berinsfield Health Centre
3. Clifton Hampden Surgery
4. Church Street Practice
5. Didcot Health Centre
6. Fern Hill Practice
7. Grove Surgery
8. Long Furlong Surgery
9. Marcham Road Surgery
10. Malthouse Surgery
11. Newbury Street Practice
12. Oak Tree Health Centre
13. White Horse Medical Practice
14. Woodlands Medical Centre

As of 1 April 2015 Fern Hill Practice merged with the White Horse Medical Practice, as such from 1 April 2015 there are 13 GP practices in the South West Locality.

West Oxfordshire

There are 9 GP practices in the locality with a population of nearly 80,000 patients. Dr Miles Carter is the Locality Clinical Director, who is supported by Dr Kiren Collison. The 9 practices are:

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

The People Behind OCCG

The names of the Clinical Chair and Chief Executive:

- Dr Joe McManners, Clinical Chair
- Ian Wilson CBE, Interim Chief Executive until May 2014
- David Smith, Chief Executive from June 2014

The composition of the Governing Body as of 31 March 2015 includes:

- Dr Julie Anderson, South West Locality Clinical Director (from 1 May 2014)
- Dr Stephen Attwood, North East Locality Clinical Director
- Dr Andrew Burnett, South East Locality Clinical Director
- Fran Butler, Practice Manager at Mill Stream Surgery, Benson, Oxfordshire representing the views of practice managers across Oxfordshire
- Dr Miles Carter, West Locality Clinical Director
- Dr David Chapman, Oxford City Clinical Director
- Mike Delaney, Lay Member (from 1 December 2014)
- Roger Dickinson, Lay Member, Lead for Governance and Vice Chair (from 7 April 2014)
- Diane Hedges, Director of Delivery and Localities (from 6 October 2014)
- John Jackson, Director of Strategy and Transformation OCCG and Director of Social Services, Oxfordshire County Council (from 1 September 2014)
- Gareth Kenworthy, Chief Finance Officer
- Dr Graziano Luzzi, Independent Specialist Clinical Doctor (advisory role)
- Dr Joe McManners, Clinical Chair
- Dr Jonathan McWilliam, Director of Public Health, Oxfordshire County Council
- Catherine Mountford, Director of Governance (from 1 September 2014)
- Dr Paul Park, North Oxfordshire Locality Clinical Director and Deputy Clinical Chair
- David Smith, Chief Executive (from 13 June 2014)
- Duncan Smith, Lay Member (from 1 May 2014)
- Louise Wallace, Lay Member for Public Participation and Involvement (PPI)
- Sula Wiltshire, Director of Quality and OCCG Lead Nurse

Other members of the Governing Body during 2014/15 included:

- Dr Gavin Bartholomew until 30 April 2014
- Ian Busby until 3 May 2014
- Lorraine Foley until 27 July 2014
- Dr Karen Kearley until 11 July 2014
- Mary Keenan until 31 October 2014
- Gina Shakespeare until 3 October 2014
- Ian Wilson until 10 June 2014

Each individual who is a member of the Governing Body at the time the Members' Report is approved confirms:

- so far as the Governing Body member is aware, that there is no relevant audit information of which the clinical commissioning group's external auditor is unaware and

- that the Governing Body member has taken all the steps that they ought to have taken as a member in order to make them self aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information.

Committees and Sub-Committees of the Governing Body: membership and attendance

The formal committees and sub-committees provide assurance and advice to OCCG's Governing Body and the Accountable Officer to ensure OCCG fulfils its duties to exercise its functions effectively, efficiently and economically, thus ensuring improvement in the quality of services and the health of the local population. The formal committees and sub-committees are shown below:

Finance and Investment Committee

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

- Dr Stephen Attwood – Locality Clinical Director for North East Locality (until31/05/14)
- Dr Julie Anderson – Locality Clinical Director for South West Locality (from 01/11/14)
- Roger Dickinson – Lay Member, Lead for Governance and Vice Chair
- Mike Delaney, CPFA – Lay Member
- Gareth Kenworthy, FCCA – Chief Finance Officer
- Duncan Smith – Lay Member
- Gina Shakespeare until September 2014 – Director of Delivery and Localities
- Diane Hedges from October 2104 – Director of Delivery and Localities

Integrated Governance and Audit Committee

The role of the Committee is to provide an independent and objective view of internal control by overseeing internal and external audit services, reviewing financial systems, monitoring compliance with Standing Orders and Prime Financial Policies, reviewing schedules of losses and compensations, reviewing the information prepared to support the controls of assurance statements, overseeing the risk management arrangements and making recommendations to the Governing Body. The role of the Committee includes financial governance, statutory reporting and assurance in respect of the principal risks and will monitor and review the systems and frameworks that are in place to manage organisational risk.

Members include:

- Ros Avery – Lay Member, Lead for Governance and Audit (until May 2014)
- Roger Dickinson – Lay Member, Lead for Governance and Vice Chair (from May 2014)
- Mike Delaney – Lay Member
- Gareth Kenworthy – Chief Finance Officer
- Duncan Smith – Lay Member
- Graziano Luzzi - Independent Specialist Clinical Doctor (advisory role)
- Catherine Mountford – Director of Governance (from September 2014)

- Sula Wiltshire – Director of Quality (until August 2014)

Quality and Performance Committee

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

Members include:

- David Chapman – Locality Clinical Director for City Locality
- Catherine Mountford – Director of Governance
- Gina Shakespeare – Director of Delivery and Localities (until September 2014)
- Diane Hedges – Director of Delivery and Localities (from October 2104)
- Louise Wallace – Lay Member for Patient And Public Involvement (Chair)
- Sula Wiltshire – Director of Quality (Vice-Chair)
- Mike Delaney, CPFA – Lay Member (from February 2014)

And:

- Assistant Director of Quality
- Assistant Director of Medicines Management
- Quality and Contracts, Service Manager (Joint Commissioning)
- GP Lead
- Nurse & Safeguarding Lead
- Director of Clinical Quality
- Deputy Director of Public Health, Oxfordshire County Council

Remuneration Committee Attendance

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.

Members include:

- Roger Dickinson – Lay Member, Lead for Governance and Vice Chair
- Dr Graziano Luzzi - Independent Specialist Clinical Doctor
- Dr Joe McManners
- Duncan Smith – Lay Member
- Louise Wallace – Lay Member for Patient And Public Involvement (Chair)

Attendance at all OCCG committee meetings throughout 2014/15 is shown in the Annual Governance Statement on page 87.

Service Contracts

OCCG has held three service contracts with senior managers who have served on the Governing Body this year:

- The Interim Chief Executive's contract commenced on 9 December 2013 and expired 13 June 2014. It had a notice period of 30 days in writing and has a provision of no compensation to be paid for early termination.
- The Interim Chief Operating Officer's contract commenced on 29 July 2013 and expired 1 October 2014. It had a notice period of 28 days in writing and had a provision of no compensation to be paid for early termination.
- The Interim Director of Delivery and Localities contract commenced from 1 October and expired on 23 February 2015. It had a notice period of 30 days in writing and had a provision of no compensation to be paid for early termination.

OCCG has not given any other payments to past senior managers.

During 2014/15 OCCG underwent an organisational restructure to ensure it was able to deliver its two and five year plans to improve health services for local people.

A number of significant changes were made to the structure of OCCG with the need to recruit to some senior positions; this proved difficult to ensure the right high calibre candidates were employed. As such there were a small number of senior interims in place during this time. All senior management positions have now been successfully recruited to.

Governing Body Profiles (as of 31 March 2015)

OCCG Governing Body comprises GP representatives, lay members, executive directors and representatives from Public Health, Adult Social Care and external Medical Specialists. Individual profiles are shown below:

Dr Julie Anderson South East Locality Clinical Director

Dr Julie Anderson is Locality Clinical Director for the South West Oxfordshire Locality and is a GP who has practised medicine for 33 years, mostly as a partner at Berinsfield Health Centre. She was also a GP Trainer (training new GPs) for many years. Julie has a long-standing interest in clinical audit and in developing best practice to improve patient outcomes. She has experience of practice-based commissioning and bringing more patient services into the community e.g. the Primary Care Memory Assessment Service so that dementia may be diagnosed in General Practice. She is the OCCG clinical lead for dementia, stroke, medical care in nursing and care homes and end of life care.

Dr Stephen Attwood, North East Locality Clinical Director

Stephen is the principal GP at Bicester Health Centre where he has practiced medicine for over 25 years. Stephen played a key role in developing health local services in North East Oxfordshire and is also involved in the Bicester Community Hospital project group. Stephen has taken an active interest and involvement in the commissioning of health services; firstly through GP fundholding; then by working with primary care trusts; and now with Oxfordshire Clinical Commissioning Group as the Clinical Lead for the North East locality. Stephen is also OCCG's clinical lead on Planned Care.

As a member of OCCG's Governing Body, Stephen's goal is to ensure that GPs and hospital colleagues work together to deliver the best possible health services as close to patients as possible.

Dr Andrew Burnett, South East Locality Clinical Director and Urgent Care Lead

Andrew is a GP in Sonning Common, where he has worked since 1985. Dr Burnett wants patients to feel that the NHS works for them and aims to use his role with OCCG to help achieve this.

Fran Butler, Practice Manager at Mill Stream Surgery, Benson, Oxfordshire

Fran represents the views and opinions of practice managers across Oxfordshire to ensure they have a say in helping to shape local health services. Fran has been the practice manager at Mill Stream Surgery at Benson, South Oxfordshire for the past six years, and brings a wealth of experience to the Governing Body. She has a Masters' in Public Health and is a trained assessor of public health practitioners.

Fran sees her role on the Governing Body as an opportunity for practice managers to influence GPs in commissioning new and innovative health services to meet the challenges facing the NHS and improve health outcomes for patients.

Dr Miles Carter, West Locality Clinical Director

Dr Miles Carter has been a GP in Oxford since 2005 and works at Eynsham Medical Group in Witney. Having studied Medicine at Guy's & St Thomas' Hospital in London and subsequently trained as a GP in Winchester he has good experience of the differing healthcare needs of rural and inner city populations.

Miles has a particular interest in ensuring the healthcare needs of an increasingly elderly, and potentially isolated, rural population are considered alongside the needs of younger residents living in urban areas.

Dr David Chapman, Oxford City Clinical Director

David has been a GP in Oxford for 16 years and trained and undertook research at the OUHT. He works at Hollow Way Medical Centre but also has an interest in Obstetric Medicine at the OUHT. David is actively involved in improving quality of services including establishing systems which feedback concerns to providers from patients and their GPs. He is clinical lead for mental health conditions for Oxfordshire and is interested in new forms of commissioning to improve outcomes for users of services.

Mike Delaney, Lay Member

Mike has been involved in shaping major changes in the Healthcare and Life Sciences sector for over 25 years. As a consultant, he provides Board level advisory services to healthcare and life science industry clients focusing on the issues of competitiveness, performance, innovation and growth and the key enablers of people, processes and technology to ensure transformation goals are achieved. His experience extends to designing and launching key NHS reforms including leading the Department of Health Assessment process for the launch of all NHS Trusts. Mike is an Associate Fellow of the Centre for the Advancement of Sustainable Medical Innovation (CASMI).

Roger Dickinson, Lay Member, Lead for Governance and Vice Chair

Roger has been a Chief Executive, General Manager and Lawyer for over 30 years, focused on governance and the delivery of science in a number of industry sectors – bio-tech/healthcare, electronics, utility and engineering. He is also Non-Executive Director of the Institute of Food Research. He is a passionate believer in the NHS in the community – working together to bring the best quality healthcare to us all.

Diane Hedges, Director of Delivery and Localities

Diane is an experienced commissioner and Director having worked in most types of organisations across the NHS. Before joining OCCG, Diane worked independently running her own company as a change consultant and interim Director. Assignments included Strategic Adviser to Surrey CCG on acute services and leading a public consultation in Bromley. She was responsible for the establishment of Bromley Healthcare, a new Social Enterprise transferring all community services from the local Primary Care Trust (PCT). Diane was Chief Executive of a PCT in Berkshire for many years whilst also leading the commissioning function for the three PCTs in the area. She has held a range of senior roles in a Strategic Health Authority, Department of Health, Local Authority, Primary Care Group and General Practice.

John Jackson, Director for Social and Community Services, Oxfordshire County Council

John is Director for Social Services at Oxfordshire County Council and has worked in local government since leaving university in 1979. Since September 2014 he has also been the Director of Strategy and Transformation for OCCG. His aim as a member of the OCCG Board is to take the opportunity to promote person-centred care as the key value of all those working in health and care.

Gareth Kenworthy, Chief Finance Officer

Gareth has held senior finance positions in the NHS for several years and most recently was Deputy Director of Finance for Oxford Health Foundation Trust. Gareth is aware of the financial challenges faced by Oxfordshire Clinical Commissioning Group in the coming years but welcomes the opportunities offered by clinical commissioning and the involvement of GPs and other health professionals to improve both the quality of services and their value for money.

Dr Graziano Luzzi, Medical Specialist Advisor

Graz qualified at Trinity College, Cambridge and Oxford University Clinical Academic Graduate School. He has held the position of clinical lecturer in infectious diseases at the University of Oxford and was appointed consultant physician in genitourinary/HIV medicine at Wycombe Hospital in 1993. He was an Associate Medical Director and Director of Medical Education before being appointed Medical Director at Buckinghamshire Healthcare NHS Trust in May 2007. In his role with OCCG he hopes to bring a provider perspective from secondary care, and to work jointly with GPs and other colleagues on a strategy and approach to commissioning which best serves the needs of the local population.

Dr Joe McManners, Clinical Chair

Joe is Clinical Chair of Oxfordshire Clinical Commissioning Group (OCCG). He is also a GP at Manor Surgery, Headington and trains GPs. He previously worked with homeless people at Luther Street medical practice and hopes to use his role on the OCCG as an opportunity to decrease inequalities, to increase integration between health and social care and make health services more suitable to older patients.

Dr Jonathan McWilliam, Director of Public Health, Oxfordshire County Council

As Director of Public Health, Jonathan's long term goal is to achieve a vision of 'One Oxfordshire' in which all organisations work together within a shared set of priorities to improve health for the long term. He is guided by the definition of public health which is to 'improve health and prevent disease through the organised efforts of society'.

Catherine Mountford, Director of Governance

Catherine has worked in the NHS for over 25 years with considerable experience as an NHS Director operating at Board and Executive team level. Whilst the majority of her roles have been within commissioning she also has experience of operational management in a combined acute, community and mental health service provider. Within a variety of commissioning roles, Catherine has focused on working with clinicians to deliver change in service pathways to improve services and outcomes for patients.

Dr Paul Park, North Locality Clinical Director

Paul is a partner at Hightown Surgery in Banbury, and is the locality clinical director for north Oxfordshire. He is also the chief clinical information officer (CCIO) for OCCG, which means that he works to make sure that information technology and informatics are a key part of health and social care planning in the county. Paul's background in clinical research also gives him a keen interest in reducing health inequalities in Oxfordshire.

David Smith, Chief Executive

David has worked in the NHS since 1975 and has a lengthy track record of service transformation and financial turnaround within the NHS, with considerable experience at Chief Executive level. David previously worked for Kingston Clinical Commissioning Group in South London where he was the Chief Officer/Accountable Officer and also the Director of Health and Adult Services for Kingston Council.

Duncan Smith, Lay Member

Duncan currently works as a Management Consultant. Prior to this he worked at Director level in the NHS and has experience working in local government and the private sector.

Professor Louise Wallace, Lay Member for Public Participation and Involvement (PPI)

Louise has 13 years of NHS experience as a Clinical Psychologist working in many general hospital services. In her role as lay member of the OCCG Board for Public Participation and Involvement (PPI), Louise provides expertise in board governance, together with research, clinical and managerial expertise that will improve the quality and safety of services and wider public health through partnerships of OCCG in Oxfordshire.

Sula Wiltshire, Director of Quality and Innovation and OCCG Lead Nurse

Sula trained as a nurse in Dublin. She has worked in a range of clinical settings including hospitals, community and primary care as well as education.

Sula's goal as a member of OCCG's governing body is to safeguard high standards in the commissioning of high quality healthcare and to ensure maintaining those high standards is a shared responsibility. She aims to ensure patients are at the heart of all OCCG's work.

OCCG Register of Interest
Governing Body Members

Name	Position	Voting Board Member	Interest
Dr Julie Anderson	Locality Clinical Director – South West Locality	✓	• Director of Berinsfield Pharmacy
Dr Stephen Attwood	Locality Clinical Director – North East Locality	✓	• GP Partner and part owner at Bicester Health Centre • Practice owns one share in Principal Medical Limited
Dr Andrew Burnett	Locality Clinical Director – South East Locality	✓	• GP Partner and part owner at Sonning Common Health Centre • Runs private allergy clinic, Spire Dunedin Hospital, Reading • Wife and daughter employed by Royal Berkshire Hospital
Fran Butler	Practice Manager Representative		• Partner is Director of Bruce Don Consulting Ltd
Dr Miles Carter	Locality Clinical Director West Oxfordshire Locality	✓	• Director, 50% owner and shareholder of QOF Masters Limited • Director and shareholder of Hanborough Medical Services • GP Partner Eynsham Medical Group • Practice owns shares in Principal Medical Limited
Dr David Chapman	Deputy Locality Clinical Director - City	✓	• GP Partner • Undertakes work for Southern Health paid via Practice • Member of the Local Medical Committee
Michael Delaney	Lay Member	✓	• Director of MFD Partners International Ltd • Director, sole owner and 100% shareholding of Blueground Professional Services Ltd
Roger Dickinson	Lay Member Lead for Governance and Vice Chair	✓	• Non Executive Director / Trustee Institute of Food Research, Norwich
Diane Hedges	Interim Director of Delivery and Localities		• Managing Director of Diane Hedges Ltd

John Jackson	Director for Social and Community Services, Oxfordshire County Council (OCC) Director of Strategy and Transformation (OCCG)		• OCC Pooled budgets with NHS
Gareth Kenworthy	Chief Finance Officer	✓	• None
Dr Graziano Luzzi	Secondary Care Specialist Doctor	✓	• Associate Medical Director, Buckinghamshire Healthcare NHS Trust
Dr Joe McManners	Clinical Chair	✓	• GP Partner at Manor Surgery • Wife works in obstetrics and gynaecology at Oxford University Hospitals Trust (OUHT)
Dr Jonathan McWilliam	Director of Public Health, Oxfordshire County Council		• Wife is a director of and holds shares in OMG Plc • OCC pooled budgets with NHS
Catherine Mountford	Director of Governance and Business Process		• None
Dr Paul Park	Locality Clinical Director – North Oxfordshire Locality	✓	• GP at Hightown Surgery • Employee of Principal Medical Limited at Banbury Health Centre • Wife is employee of Citizen's Advice Bureau
David Smith	Chief Executive	✓	• Wife owner of Imagine Your Potential and works in the NHS, local government and private sector
Duncan Smith	Lay Member	✓	• Partner in Dudley Smith Limited Management Consultants. Wife also partner in the business.
Professor Louise Wallace	Lay Representative – Patient and Public Involvement	✓	• Director and Shareholder of Health Behaviour Research Limited • Employee of Coventry University
Sula Wiltshire	Director of Quality and Innovation and Lead Nurse	✓	• Daughter employed as Nurse at Oxford University Hospitals Trust

Other OCCG employees who are members of Committees of the Governing Body

Name	Position	Interests
Cecile Coignet	Assistant Director for Information and Performance	• None
Dr Kiren Collinson	Deputy Locality Clinical Director – West Oxfordshire Locality	• Salaried GP at Eynsham Medical Group • Locum GP • Registered to work in out of hours • Partner is a radiologist employed by Oxford University Hospital Trust
Julie Dandridge	Assistant Director Medicines Management	• Previously employed by OUHT
Dr Richard Green	Clinical Director Quality and Innovation	• GP Partner at Donnington Health Centre (Anscombe and Partners)

Pensions

Information relating to pensions are included in the remuneration report on page 60 and in the notes to accounts on page XX.

Financial Information - Accounts Year Ended 31 March 2015

The following is a glossary of terms that is used throughout the Summary Financial Statements.

Statement of Comprehensive Net Expenditure

This statement records the income and expenditure incurred by the Clinical Commissioning Group during the year in the course of running its operations. It includes cash expenditure on staff, supplies and contracts, commissioning healthcare as well as non-cash expenses such as depreciation. It is the equivalent of the profit and loss account in the private sector but is measured against the Resource Limit to determine whether or not a surplus or deficit has occurred. Terms used within this statement include:

- Programme Expenditure - services supplied by other organisations outside the Clinical Commissioning Group
- Administration Costs – relates to expenditure which is not a direct cost of healthcare such as employee costs and Head Office building.
- Other operating revenue - income received for supply of goods and services to other organisations.
- Net Operating costs - income received less expenditure

Statement of Financial Position (Balance Sheet)

Statement of the Clinical Commissioning Group's financial position at a specific moment in time; the end of the financial year. It lists Assets (everything the Clinical Commissioning Group owns in monetary terms), liabilities (amounts owed to external parties) and taxpayers' equity (the assets minus liabilities). Terminology covers:

- Property, Plant and Equipment - which is Land, buildings, equipment and fixture and fittings
- Non Current Assets - represent rights or other access to future economic benefits controlled by the Clinical Commissioning Group as a result of past transactions or events which will materialise in the future greater than twelve months
- Current Assets - rights or other access to future economic benefits controlled by the Clinical Commissioning Group as a result of past transactions or events which will materialise within the next twelve months
- Inventories - items purchased for future use
- Trade and Other Receivables - amounts owed to the Clinical Commissioning Group at the Balance Sheet date
- Cash and Cash equivalents- cash held in banks and in hand
- Liabilities - obligation of the Clinical Commissioning Group to transfer economic benefits as a result of past transactions or events
- Provisions - liabilities in which the amount and timing is uncertain. While there has been no cash payment, the Clinical Commissioning Group anticipates making a payment at a future date and so its net assets are reduced accordingly
- General Fund - represents the funds needed but not yet sought from DH that is required to meet the cost of goods and services received less cash not received for services provided and payments/investments made in fixed assets

Cash Flow Statement

This is a summary of the cash flow of the Clinical Commissioning Group during the accounting period. This includes the impact of operating and investment activities, capital transactions and financing. Terms applied are:

- Net Cash Outflow from Activities - relates to cash spent from normal operating activities
- Capital Expenditure - payments for new capital assets and receipts from asset sales. Capital expenditure relates to spending on buildings, land and equipment which exceeds £5,000
- Net Cash Inflow from Financing - the total amount of cash the Clinical commissioning Group has been given by the Department of Health
- Net Funding - money given to the Clinical Commissioning Group by the Department of Health to spend on the provision of services

Summary Financial Statements 2014/2015

Statement of Comprehensive Net Expenditure for the year ended 31 March 2015

	Note	2014-15 £000	2013-14 £000
Total Income and Expenditure			
Employee benefits	4.1.1	7,007	6,012
Operating Expenses	5	654,730	642,269
Other operating revenue	2	(14,409)	(17,967)
Net operating expenditure before interest		**647,327**	**630,314**
Investment Revenue	8	0	0
Other (gains)/losses	9	0	0
Finance costs	10	0	0
Net operating expenditure for the financial year		**647,327**	**630,314**
Net (gain)/loss on transfers by absorption	11	0	0
Total Net Expenditure for the year		**647,327**	**630,314**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	6,645	5,827
Operating Expenses	5	10,966	12,722
Other operating revenue	2	(3,201)	(3,360)
Net administration costs before interest		**14,409**	**15,189**
Programme Income and Expenditure			
Employee benefits	4.1.1	362	185
Operating Expenses	5	643,764	629,547
Other operating revenue	2	(11,208)	(14,607)
Net programme expenditure before interest		**632,918**	**615,124**

Other Comprehensive Net Expenditure		2014-15 £000	2013-14 £000
Impairments and reversals	22	0	0
Net gain/(loss) on revaluation of property, plant & equipment		0	0
Net gain/(loss) on revaluation of intangibles		0	0
Net gain/(loss) on revaluation of financial assets		0	0
Movements in other reserves		0	0
Net gain/(loss) on available for sale financial assets		0	0
Net gain/(loss) on assets held for sale		0	0
Net actuarial gain/(loss) on pension schemes		0	0
Share of (profit)/loss of associates and joint ventures		0	0
Reclassification Adjustments		0	0
On disposal of available for sale financial assets		0	0
Total comprehensive net expenditure for the year		**647,327**	**630,314**

The notes on pages 95 to 131 form part of this statement

Statement of Financial Position as at 31 March 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets:			
Property, plant and equipment	13	493	0
Intangible assets	14	0	0
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		**493**	0
Current assets:			
Inventories	16	0	0
Trade and other receivables	17	13,279	9,823
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	(0)	0
Total current assets		**13,279**	9,823
Non-current assets held for sale	21	0	0
Total current assets		**13,279**	9,823
Total assets		**13,772**	9,823
Current liabilities			
Trade and other payables	23	(33,490)	(34,141)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	(655)	(632)
Provisions	30	0	0
Total current liabilities		**(34,145)**	(34,773)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(20,373)**	(24,950)
Non-current liabilities			
Trade and other payables	23	0	0
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(848)	(1,159)
Total non-current liabilities		**(848)**	(1,159)
Assets less Liabilities		**(21,220)**	(26,109)
Financed by Taxpayers' Equity			
General fund		(21,220)	(26,109)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(21,220)**	(26,109)

The notes on pages 95-131 form part of this statement

The financial statements on pages 90-131 were approved by the Governing Body on [date] and signed on its behalf by:

Chief Accountable Officer

David Smith

Statement of Cash Flows for the year ended 31 March 2015

	Note	2014-15 £000	2013-14 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(647,327)	(630,315)
Depreciation and amortisation	5	38	0
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	(3,456)	(9,823)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(651)	34,141
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	(312)	1,159
Net Cash Inflow (Outflow) from Operating Activities		**(651,708)**	(604,838)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(531)	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**(531)**	0
Net Cash Inflow (Outflow) before Financing		**(652,239)**	(604,838)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		652,216	604,206
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Net Cash Inflow (Outflow) from Financing Activities		**652,216**	604,206
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(22)**	(632)
Cash & Cash Equivalents at the Beginning of the Financial Year		**(632)**	0
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**(655)**	(632)

Remuneration Report

Each CCG has a Remuneration committee, the role of which is to determine and approve the remuneration package for senior managers and CCG employees. Membership of the remuneration committee at OCCG is made up of the following lay members;

- Dr Joe McManners
- Roger Dickinson
- Graziano Luzzi
- Duncan Smith
- Louise Wallace

Remuneration is designed to fairly reward each individual based on their contribution to the organisation's success taking into account the need to recruit, retain and motivate skilled and experienced professionals. This is not withstanding the need to be mindful of not paying more than is necessary in order to ensure value for money in the use of public resources and the OCCG's running cost allowance.

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 Governing Body have employment contracts and are paid via payroll.

Salary and Allowance of Senior Managers of Oxfordshire Clinical Commissioning Group 2014/15

Name	Title	Salary & Fees (Bands of £5000) £000	Taxable benefit (rounded to nearest £100) £000	Annual Performance Related Bonuses £000	Long Term Performance Related Bonuses £000	All Pension Related Benefits (Bands of £2500) £000	TOTAL (Bands of £5000) £000
Ursula Wiltshire	Director of Quality and Innovation	100-105	0	0	0	0-2.5	100-105
Gareth Kenworthy	Chief Financial Officer	105-110	0	0	0	2.5-5	105-110
Mary Keenan	Medical Director (until 31/10/14)	60-65	0	0	0	20-22.5	85-90
Lorraine Foley	Director of Commissioning and Partnerships (until 27/7/14)	60-65	0	0	0	10-12.5	70-75
Ian Wilson	Interim Chief Executive (until 10/6/14)	85-90	0	0	0	0-2.5	85-90
Gina Shakespeare	Interim Chief Operating Officer (until 3/10/14)	140-145	0	0	0	0-2.5	140-145
David Smith	Chief Executive (from 13/06/14)	125-130	0	0	0	180-185	310-315
Stephen Attwood	Locality Clinical Director	60-65	0	0	0	7.5-10	65-70
Miles Carter	Locality Clinical Director	50-55	0	0	0	2.5-5	55-60
Paul Park	Locality Clinical Director	60-65	0	0	0	2.5-5	65-70
Joe McManners	Clinical Chair	80-85	0	0	0	0-2.5	80-85
Andrew Burnett	Locality Clinical Director	35-40	0	0	0	0-2.5	35-40
Gavin Bartholomew	Locality Clinical Director (until 30/4/14)	5-10	0	0	0	32.5-35	35-40
David Chapman	Locality Clinical Director	45-50	0	0	0	0-2.5	45-50
Karen Kearley	Locality Clinical Director (until 11/7/14)	5-10	0	0	0	12.5-15	20-25
Graz Luzzi	Secondary Care Specialist	10-15	0	0	0	0-2.5	10-15
John Jackson	Director of Strategy and Transformation / Director for Social and Community Services (OCC) 50% Oxfordshire County Council	60-65	0	0	0	0-2.5	60-65

Name	Title	Salary & Fees (Bands of £5000) £000	Taxable benefit (rounded to nearest £100) £000	Annual Performance Related Bonuses £000	Long Term Performance Related Bonuses £000	All Pension Related Benefits (Bands of £2500) £000	TOTAL (Bands of £5000) £000
Catherine Mountford	Director of Governance (from 1/9/14)	55-60	0	0	0	2.5-5	60-65
Jonathan McWilliam	Director of Public Health, OCC	N/R	0	N/A	N/A	N/A	N/A
Julie Anderson	Locality Clinical Director (from 1/5/14)	55-60	0	0	0	0-2.5	55-60
Diane Hedges	Interim Director of Delivery and Localities (from 6/10/14 to 23/2/15)	115-120	0	0	0	0-2.5	115-120
Diane Hedges	Director of Delivery and Localities (from 23/2/15)	10-15				0-2.5	10-15
Ian Busby	Chair (until 3/5/14)	0-5	0	0	0	0-2.5	0-5
Louise Wallace	Lay Member	10-15	0	0	0	0-2.5	10-15
Roger Dickinson	Lay Member, Lead for Governance and Vice Chair (from 7/4/14)	15-20	0	0	0	0-2.5	15-20
Mike Delaney	Lay Member (from 1/12/14)	0-5	0	0	0	0-2.5	0-5
Duncan Smith	Lay Member (from 1/5/14)	10-15	0	0	0	0-2.5	10-15
Fran Butler	Practice Manager Representative	0-5	0	0	0	0-2.5	0-5

Salary and Allowance of Senior Managers of Oxfordshire Clinical Commissioning Group CCG 2013/14

Name	Title	Salary & Fees (Bands of £5000) £000	Taxable benefit (rounded to nearest £100) £000	Annual Performance Related Bonuses £000	Long Term Performance Related Bonuses £000	All Pension Related Benefits (Bands of £2500) £000	TOTAL (Bands of £5000) £000
Stephen Richards	Accountable Officer (1/04/13 to 3/2/14)	130-135	0	0	0	0	130-135
Ursula Wiltshire	Director of Quality and Innovation	95-100	0	0	0	25-27.5	120-125
Gareth Kenworthy	Chief Financial Officer	105-110	0	0	0	2.5-5	135-140
Mary Keenan	Medical Director	110-115	0	0	0	0-2.5	110-115
Lorraine Foley	Director of Commissioning and Partnerships	105-110	0	0	0	0	105-110
Ian Wilson	Interim Chief Executive (from 1/10/13)	105-110	0	N/A	N/A	N/A	105-110
Gina Shakespeare	Interim Chief Operating Officer (from 1/10/13)	115-120	0	N/A	N/A	N/A	115-120
Stephen Attwood	Locality Clinical Director	60-65	0	0	0	10-12.5	70-75
Miles Carter	Locality Clinical Director	45-50	0	0	0	0-2.5	45-50
Paul Park	Locality Clinical Director	45-50	0	0	0	235-237.5	280-285
Joe McManners	Clinical Chair (from 3/2/14)	75-80	0	0	0	55-57.5	130-135
Andrew Burnett	Locality Clinical Director	45-50	0	0	0	15-17.5	60-65
Gavin Bartholomew	Locality Clinical Director	60-65	0	0	0	0-2.5	60-65
David Chapman	Locality Clinical Director (from 3/2/14)	30-35	0	0	0	0-2.5	30-35
Karen Kearley	Locality Clinical Director (from 3/2/14)	45-50	0	0	0	0	45-50
Joe Santos	Locality Clinical Director (until June 2013)	5-10	0	0	0	0	5-10
Peter Von Eichstorff	Locality Clinical Director (until 13/10/13	20-25	0	0	0	72.5-75	95-100

Name	Title	Salary & Fees (Bands of £5000) £000	Taxable benefit (rounded to nearest £100) £000	Annual Performance Related Bonuses £000	Long Term Performance Related Bonuses £000	All Pension Related Benefits (Bands of £2500) £000	TOTAL (Bands of £5000) £000
Graz Luzzi	Secondary Care Specialist	10-15	0	N/A	N/A	N/A	10-15
John Jackson	Director of Strategy and Transformation / Director for Social and Community Services (OCC) 50% Oxfordshire County Council	N/R	0	N/A	N/A	N/A	N/R
Jonathan McWilliam	Director of Public, OCC	N/R	0	N/A	N/A	N/A	N/A
Ian Busby	Chair	40-45	0	N/A	N/A	N/A	40-45
Louise Wallace	Lay Member	10-15	0	N/A	N/A	N/A	10-15
Andrew McHugh	Practice Manager Representative (until September 2013)	0-5	0	N/A	N/A	N/A	0-5
Fran Butler	Practice Manager Representative (from November 2013)	0-5	0	N/A	N/A	N/A	0-5

N/A - Not applicable

N/R – No remuneration

Please note:

i) No senior manager received a bonus due to OCCG not achieving all of its financial planning requirements

ii) John Jackson - 50% salary recharge from Oxfordshire County Council in 2014/15- this figure includes VAT which is non recoverable to Oxfordshire Clinical Commissioning Group

Pension Benefits – Greenbury Disclosure 2014/15

Name	Title	Real increase in pension at age 60 (bands of £2,500) £'000	Real increase in pension lump sum at age 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000) £'000	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2015 £'000	Cash Equivalent Transfer Value at 1 April 2014 £'000	Real increase in Cash Equivalent Transfer Value £'000	Employer's contribution to partnership pension £'000
Ursula Wiltshire	Director of Quality and Innovation	0-2.5	0-2.5	30-35	95-100	0	0	0	0
Gareth Kenworthy	Chief Financial Officer	0-2.5	0-2.5	20-25	70-75	341	312	20	0
Mary Keenan	Medical Director	0-2.5	0-2.5	15-20	45-50	325	282	21	0
Lorraine Foley	Director of Commissioning and Partnerships	0-2.5	0-2.5	10-15	35-40	233	209	11	0
David Smith	Chief Executive	5-7.5	20-22.5	75-80	235-240	1,735	1,456	192	0
Stephen Attwood	Locality Clinical Director	0-2.5	0-2.5	5-10	25-30	208	182	21	0
Miles Carter	Locality Clinical Director	0-2.5	0-2.5	5-10	25-30	107	96	9	0
Paul Park	Locality Clinical Director	0-2.5	0-2.5	10-15	40-45	200	181	14	0
Joe McManners	Clinical Chair	0-2.5	0-2.5	10-15	30-35	142	133	6	0
Andew Burnett	Locality Clinical Director	0-2.5	0-2.5	10-15	35-40	250	236	8	0
Gavin Bartholomew	Locality Clinical Director	0-2.5	0-2.5	10-15	35-40	266	229	3	0
David Chapman	Locality Clinical Director	0-2.5	0-2.5	25-30	85-90	631	600	15	0

Name	Title	Real increase in pension at age 60 (bands of £2,500) £'000	Real increase in pension lump sum at age 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000) £'000	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2015 £'000	Cash Equivalent Transfer Value at 1 April 2014 £'000	Real increase in Cash Equivalent Transfer Value £'000	Employer's contribution to partnership pension £'000
Karen Kearley	Locality Clinical Director	0-2.5	0-2.5	10-15	35-40	243	219	5	0
Catherine Mountford	Director of Governance	0-2.5	0-2.5	30-35	95-100	458	438	5	0
Diane Hedges	Director of Delivery and Localities	0-2.5	0-2.5	15-20	50-55	379	367	0	0

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Values

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.

Exit Packages

Exit packages cost band (including special payment element)	Compulsory Redundancies Number	Compulsory Redundancies £'	Other Agreed Departures Number	Other Agreed Departures £'	Total Number	Total £'	Departures where special payments have been made Number	Departures where special payments have been made £'	Min (excl.) £'	Max (excl.) £'
Less than £10,000	0	0	0	0	0	0	0	0	0	10,001
£10,001 to £25,000	0	0	3	47,406	3	47,406	0	0	10,000	25,001
£25,001 to £50,000	0	0	0	0	0	0	0	0	25,000	50,001
£50,001 to £100,000	0	0	2	134,651	2	134,651	0	0	50,000	100,001
£100,001 to £150,000	0	0	1	135,610	1	135,610	0	0	100,000	150,001
£150,001 to £200,000	0	0	0	0	0	0	0	0	150,000	200,001
Over £200,001	0	0	0	0	0	0	0	0	200,000	1,000,000,000
Total CCG	0	0	6	317,667	6	317,667	0			

Redundancy and other departure costs have been paid in accordance with the provisions of the voluntary redundancy scheme. Exit costs in this note are accounted for in full in the year of departure. Where OCCG has agreed early retirement, the additional costs are met by OCCG and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

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

	Other Agreed Departures Number	Other Agreed Departures £'
	N4AJ	N4AK
Voluntary redundancies including early retirement contractual costs	6	317,667
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total CCG	6	317,667

Workforce Remuneration

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 in OCCG (permanent employee) in the financial year 2014/15 was £160-£165k (2013/14 - £130K to £135k), on an annualised basis. This was 3.8 times (2013/14 - 5.4 times) the median remuneration of the workforce, which was £42,191 (2013/14 £ 24,250).

In 2014/15, no employees received remuneration in excess of the highest-paid Director. Remuneration ranged from £13,000 to £160,000 (2013/14 - £ 1K to £132K).

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.

For both 2013/14 the highest paid Director is a permanent member of staff. The remuneration range for both years is all individuals paid via payroll which includes allowances for Lay members of the Governing Body as well as employees and in 2013/14 this included a part-year effect. In 2014/15 the ratio of the median remuneration to that of the highest paid Director has decreased. This is mainly driven by the increase of the median salary between the two years. In line with guidance the calculation of the median salary includes payments made to interim staff.During 2014/15 OCCG underwent an organisational restructure to ensure it was able to deliver its two and five year plans to improve health services for local people.

A number of significant changes were made to the structure of OCCG with the need to recruit to some senior positions; this proved difficult to ensure the right high calibre candidates were employed. As such there were a small number of senior interims (as reported on pages 47, 72 and 73) in place during this time. All senior management positions have now been successfully recruited to.

Public Sector Payment Policy

The non-NHS creditor policy of the Clinical Commissioning Group complies with both the CBI Better Payments Practice Code and with Government accounting rules.

The non-NHS trade creditor payment policy of the Trust is to comply with both the CBI Prompt Payment code and Government Accounting Rules.

Government Accounting Rules state that 'the timing of payment should normally be stated in the contract, where there is no contractual provision departments should pay within 30 days of receipt of goods and services or the presentation of a valid invoice, whichever is the later'. As a result of this Policy the Trust ensures that:

- a clear, consistent policy of paying bills in accordance with contract exists, and that finance and purchasing divisions are aware of this policy
- payment terms are agreed at the outset of a contract and are adhered to
- payment terms are not altered without prior agreement with the supplier
- suppliers are given clear guidance on payment procedures
- a system exists for dealing quickly with disputes and complaints (where written complaints are received, these receive a written reply within 5 working days).
- bills are paid within 30 days of receipt of services or invoice, unless covered by other agreed payment terms or are in dispute

The Clinical Commissioning Group compliance was:

	31-Mar-15 Number	31-Mar-15 £'000	31-Mar-14 Number	31-Mar-14 £'000
Non-NHS Payables: CCG				
Total Non-NHS trade invoices paid in the year	3,384	91,169	2,322	73,115
Total Non-NHS trade invoices paid within target	**2,929**	**84,860**	**2,031**	**69,112**
Percentage of CCG non-NHS trade invoices paid within target	86.55%	93.08%	87.47%	94.53%
NHS Payables: CCG				
Total NHS trade invoices paid in the year	3,890	477,443	2,414	514,777
Total NHS trade invoices paid within target	**3,612**	**477,003**	**2,206**	**388,426**
Percentage of CCG NHS trade invoices paid within target	92.85%	99.91%	91.38%	75.46%

The Better Payment Practice Code requires Clinical Commissioning Groups to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, which is later.

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 at 31 March 2015, for more than £220 per day and that last longer than 6 months.

	Number
Number of existing engagements as of 31 March 2015	**5**
for less than one year at the time of reporting	4
for between one and two years at the time of reporting	1
for between two and three years at the 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 2014 and 31 March 2015, for more than £220 per day and that last longer than 6 months.

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015.	13
Number of new engagements which include contractual clauses giving OCCG the right to request assurance in relation to income tax and National Insurance obligations	13
Number for whom assurance has been requested	8
Of which:	0
assurance has been received	8
assurance has not been received	0
engagements terminated as a result of assurance not being received, or ended before assurance received	0

iii) For any off-payroll engagements of board members and/or senior officials with significant financial responsibility between 1 April 2014 and 31 March 2015.

	Number
Number of engagements of board members and senior officials with significant financial responsibility during the year	3

Significant Financial influence

No. of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	6

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 the David Smith to be the Accountable Officer of the Clinical Commissioning Group.

The responsibilities of an Accountable Officer, including 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) and for safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Clinical Commissioning Group Accountable Officer Appointment Letter.

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 *Manual for Accounts* 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 *Manual for Accounts* 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 in my Clinical Commissioning Group Accountable Officer Appointment Letter.

David Smith
Accountable Officer
[x] May 2015

Annual Governance Statement

Governance Statement
Oxfordshire Clinical Commissioning Group (OCCG) was licenced from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006.

As at 1 April 2014, OCCG was licenced without conditions. All conditions were formally discharged at the CCG Authorisation and Assurance Committee meeting on 12 December 2013.

Scope of Responsibility
For 2014 / 2015 the role of Accountable Officer was fulfilled by Ian Wilson until 10 June 2014 when I assumed the position. 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 in my Clinical Commissioning Groups 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 property and regularity.

Compliance with the 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 on best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to OCCG and best practice.

OCCG is headed by an effective Governing Body with a clear division of responsibilities between the running of the Governing Body and the Executive responsibilities for running the business. The Chairman has overall responsibility for running the Governing Body.

The Governing Body and its committees have an appropriate balance of skills, experience, knowledge and independence to enable them to discharge their responsibilities. The Governing Body and its committees are supplied with information in a timely manner to enable discharge of their responsibilities. All Directors are allocated sufficient time to discharge their duties.

The Governing Body maintains sound risk management and internal control systems supported by a Risk Management Policy and Strategy.

Directors' remuneration is designed to promote the long-term success of OCCG. No Directors are involved in determining their pay.

The Governing Body undertakes regular dialogue with stakeholders which is based on mutual understanding of objectives.

The Clinical Commissioning Group Assurance Framework
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 Governing Body are detailed in OCCG's Constitution and supporting documents, including scheme of delegation, standing orders, prime financial policies, roles and responsibilities and locality constitutions.

Through agreement of the Constitution the Membership Body has agreed that the Governing Body will be responsible for:

- Assurance, including audit and remuneration
- Assuring the decision making arrangements
- Oversight of arrangements for dealing with conflicts 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 Membership Body is represented on the Governing Body through the Locality Clinical Directors who are appointed in line with the Locality Constitutions.

In accordance with the Constitution, the Governing Body has held 6 meetings in public since May 2014 in this period. All meetings were quorate in terms of executive and lay member representation. A table of attendance is included at Appendix A.

The 2014 / 2015 Governing Body agenda has focussed on the organisational objectives, national priorities and the local health economy's priorities as detailed in the Operational Plan. The Governing Body has also held workshops on strategic and corporate objectives.

Standing agenda items include the Chief Executive Report, Finance Report, Quality and Performance Report and the Assurance Framework. In addition to the standing agenda items the Governing body agenda in 2014 / 2015 has included reporting on:

- Older People's Strategy
- Proposed Changes to Patient Transport Services
- Outcomes Based Contracting
- Emergency Preparedness. Resilience and Response Annual Report and Improvement Plan
- Integrated Governance and Audit Committee Annual Report
- Primary Care Co-commissioning Report
- Safeguarding Activity Update

In line with best practice in governance, the Accountable Officer meets regularly with Directors and performance has been reviewed. The Clinical Chair meets regularly with lay members.

Performance reviews and objective setting for the Locality Clinical Directors is undertaken by the Chairman and the Deputy Clinical Chair.

Governing Body Committees

Integrated Governance and Audit Committee

The role of the Committee is to provide an independent and objective view of internal control by overseeing internal and external audit services, reviewing financial systems, monitoring compliance with Standing Orders and Prime Financial Policies, reviewing schedules of losses and compensations, reviewing the information prepared to support the controls of assurance statements, overseeing the risk management arrangements and making recommendations to the Governing Body. The role of the Committee includes financial 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 Governing Body with remaining members comprising two other lay members, Specialist Medical Adviser and one Locality Clinical Director. The following officers of OCCG and external representatives are expected to be in attendance: Director of Finance, Director of Governance, representation from internal and external audit. A table of attendance is included at Appendix A.

The Integrated Governance and Audit Committee have met 8 times during 2014 / 2015 and fulfilled its remit and responsibilities as detailed in the annual work plan. The Committee receives regular updates on governance and risk, external audit, internal audit, security management, general audit matters and financial matters. The Committee undertook a self-assessment in September 2014 following which a development plan and objectives were developed.

The following internal audit reports have been received:

- Continuing Healthcare
- Community Provider Contract Management
- Internal Governance
- QIPP
- Partnership Governance
- Information Governance
- Non-Contract Activity
- Data Quality Invoice Validation
- Quality – Safeguarding Adults (in progress)
- Critical Financial Assurance (in progress)
- Information Governance training

The minutes of the Integrated Governance and Audit Committee are made available to the public with the Governing Body papers.

Finance and Investment Committee

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

The Committee comprises at least 6 Governing Body members including 3 lay members, one Locality Clinical Director, Director of Finance and Director of Delivery and Localities. Other members of OCCG management and external advisers may be invited to attend where appropriate. The Lay Member (Finance) undertakes the role of Chair. A table of attendance is included at Appendix A.

The Finance and Investment Committee met 12 times during 2014 / 2015. In addition to standing items reporting progress on finance, business cases and financial risk, the Committee has received reports and updates including:

- Continuing Health Care Performance
- Procurement Workplan
- Better Care Fund
- Bicester / Townlands Update
- Commissioning Intentions
- Contract negotiation strategies
- Locality budgets
- Prescribing Dashboard and Incentive Scheme

The minutes of the Finance and Investment Committee are made available to the public with the Governing Body papers.

Quality and Performance Committee

The Role of the Quality and Performance 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 the arrangements for safeguarding, co-operating with the local authority in the operation of the Safeguarding Children and Safeguarding Adults Boards.

The Committee is Chaired by the lay member with responsibility for patient and public involvement who is a voting member along with the Director of Quality, two locality clinical representatives and the Director of Delivery and Localities. Non-voting ex-officio attendees of the committee comprise Clinical Director of Quality, Director of Governance, Health of Business Intelligence, Programme Manager Primary Care and Medicines Management, Assistant Director Quality, Deputy Director Joint Commissioning (OCC), Deputy Director Public Health (OCC), Clinical Support Unit representative, Patient representative. A table of attendance is included at Appendix A.

The Quality and Performance Committee met 6 times during 2014 / 2015 and in addition to standing agenda items on quality and performance reports and risk register, clinical effectiveness inspections and reviews the committee has received reports and updates on:

- Francis Report Update and Assurance from provider trusts
- Monitoring quality and improvement in primary care
- Friends and Family update
- 111 Annual Report
- Annual Prescribing Report
- Adult and Children Annual Safeguarding Report
- Serious Incidents Requiring Investigation Report

The minutes of the Quality and Performance Committee are made available to the public with the Governing Body papers.

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 Vice Chair of the Governing Body with the Chair of the Governing Body and two other lay members making up the membership. The Accountable Officer and Human Resources lead and other external advisors will be asked to support the Committee as required. A table of attendance is included at Appendix A.

The Remuneration Committee met 5 times during 2014 / 2015 and fulfilled its remit and responsibilities focusing on:

- Executive Directors PRP, Remuneration and Terms and Conditions
- Governing Body and Executive Director appointments and associated Terms and Conditions
- Changes in Locality Clinical Director appointments
- National Insurance and Tax obligations
- Voluntary Redundancy Scheme
- Recruitment and Retention Premia

Where appropriate the Committee reports in writing to the Governing Body the basis of its decisions and recommendations.

Commissioning Board

The Commissioning Board was established by agreement between OCCG, Oxfordshire County Council (OCC) and NHS England as a starting point in developing closer working relationships and is designed to fit with existing governance structures of individual organisations. The first meeting of the group was held in March. The Commissioning Board will incorporate the function of the Joint Committee for commissioning primary care.

The Clinical Commissioning Group Risk Management Framework

OCCG recognises that risk management is an essential part of good governance and is committed to ensuring that risk management is integral to all aspects of its activities. OCCG has developed a Risk Management Strategy and Policy to provide guidance to all staff on the management of strategic and operational risks within the organisation and help to identify, analyse, evaluate and reduce the risks that threaten delivery of our key objectives.

Two risk registers are used by OCCG – Operational Risk Register and Strategic Risk register (previously Board Assurance Framework). The Strategic Risk register is used by the Governing Body to identify, monitor and evaluate risks. It is used alongside other key management tools, such as financial reporting, to give the Governing Body a comprehensive picture of the organisational risk profile. The operational risk register outlines risks to the objectives of teams

and services. The Governance team co-ordinates production of these risk registers, ensuring that the document is up to date and complete and provide training where needed.

Risk management is embedded in all activities of OCCG, including operational and performance management, the annual planning cycle and project management. The Governance team works very closely with the Programme Management Office to ensure the quality of the risk logged in the register.

The Risk Management Strategy and Policy provides guidance to all staff on the management of strategic and operational risks within the organisation. Staff are trained and supported to manage risk in a way appropriate to their level of authority and duties. This occurs through on-line training and the regular review processes of the strategic and operational risk registers as well as through Project Management Office processes.

The Clinical Commissioning Group 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.

Strategic risks are raised by the Executive / Senior Managers and drafts are presented to the Executive. Strategic risks are only closed with approval from the Governing Body while the operational risks are closed with the approval of a department or service head. The Governance team maintains the risk cycle for OCCG and ensures that strategic as well as operational risks are added and updated in the correct risk cycle. The team also ensures mitigation is described fully and in a consistent format and co-ordinates with the manager assigned against every risk logged in the system.

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 developed information governance processes and procedures in line with the information governance toolkit. We have ensured that all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation.

OCCG submitted the Information Governance Toolkit with an improved score of 74% achieving a level 2 or above against all 28 requirements.

Risk Assessment in Relation to Governance, Risk Management and Internal Control

The strategic risk register was revised and approved by the Integrated Governance and Audit Committee and Governing Body, in consultation with Executive Directors. This framework is reviewed continuously throughout the year.

The attached table provides a summary of operational risks as considered by the Governing Body in March 2015 – OCCG Operational Risk Register (Red) Executive Summary

A copy of the Executive summaries that were presented to the Governing Body are attached with this statement. – OCCG Strategic Risk Register Executive summary.

Review of Economy, Efficiency and Effectiveness of the use of Resources

OCCG receives the lowest allocation per head of population in England and is one of the most underfunded CCG in comparison to its target allocation. As such OCCG must seek performance that is in the top decile of comparative performance and must seek to contract with highly efficient providers to allow it to live within its funding allocation.

OCCG's savings (QIPP) plans are informed by a range of comparative benchmarking information to locate opportunities. This information has been shared, reviewed and prioritised for development with the involvement of the Governing Body. These opportunities are then developed into business cases for implementation. OCCG has struggled with delivery of these business cases during 2014 / 2015. The introduction of project management arrangements including a PMO and standard operating framework of the delivery and management of change has seen improvements. Business cases for savings are reviewed and approved by the Governing Body having been through scrutiny in committees. Delivery is monitored the same way.

In 2014/15 OCCG delivered savings of £4.4m against a target of £15.74m. Given this level of delivery the Finance and Investment Committee continued to meet monthly to give oversight. OCCG gas requested an audit early in 2015/16 to review the approach to savings plan in order to understand how to improve delivery.

OCCG has processes in place to secure economy, efficiency and effectiveness through its procurement, contract negotiation and contract management processes. Effectiveness is monitored specifically through the quality processes and committee. In addition, OCCG has invested in developing alternative approaches to contracting that have a clear focus on improving outcomes for patients while delivering economic benefits to OCCG.

As part of their annual audit, OCCG's external auditors are required to satisfy themselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources. Their audit work is made available to and reviewed by the Integrated Governance and Audit Committee.

Review of the Effectiveness of Governance, Risk Management and Internal Control

As Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group.

The outcome of the half year Service Auditor Report undertaken on CSCSU was disappointing. An action plan has been developed and an external agency will be employed to undertake checks as to compliance in areas identified for improvement.

Through the review of the constitution, consideration was given to how the Committees of the Governing Body function and operate and amendments made as necessary. A process has been established to ensure that in future an annual review of their effectiveness is undertaken to ensure they have met their remit and responsibilities as outlined in the terms of reference.

Capacity to Handle Risk

Responsibility for oversight and management of the risk registers lies with the Director of Governance, with support from the Governance Team.

The Governance team is working closely with the Programme Management Office to ensure that staff have a good understanding of Operational and Strategic risks and there are embedded system prompts to ensure risk management is part of the project design.

Review of Effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, Directors and senior 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 advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body and Committees, if appropriate and a plan to address weaknesses, for example responses to audit recommendations and ensure continuous improvement of the system is in place.

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:

Head of Internal Audit Opinion on the Effectiveness of the System of Internal Control for the Year Ended 31 March 2015

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the Board in the completion of its Annual Governance Statement (AGS).

My opinion is set out as follows:

1. Overall opinion;
2. Basis for the opinion; and
3. Commentary.

My overall opinion is that:

Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk;

The basis for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
2. An assessment of the range of individual opinions arising from risk-based audit assignments, contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

DESIGN & OPERATION OF ASSURANCE FRAMEWORK AND ASSOCIATED PROCESSES

We carried out this review in October 2014, and at time our key findings were:-

The CCG's Risk Management Policy stated that the 'Chief Executive has overall accountability and responsibility for Risk Management within the CCG' and that the 'Director of Quality and Innovation is responsible for maintenance of the risk register and for co-ordination of risk management systems within the CCG'. However, from December this responsibility will be transferred to the Governance and Business Processes Directorate.

Training was provided to the Governing Body by Internal Audit (Director), alongside the Director of Quality and Innovation in January 2014. The Director of Quality and Innovation did however state that the Governing Body's role had altered in as much as that the summary of risks presented to its members was very high level and they expected to be assured that risk was well managed in the organisation rather than taking a hands-on approach. As it stands, training for the Integrated Governance and Audit Committee (IGAC) members who are active parties in corporate risk management and assurance will be geared towards their needs and function in the future.

Governing Body (GB) meetings took place every two months, and the Assurance Framework (AF) was reviewed at each of these. The IGAC monitored the AF and Risk Register (RR) in its meetings, which occurred every two months. Review of minutes for both the GB and IGAC confirmed that the AF and overall risk management process was effectively integrated with the annual cycle of both GB and IGAC business.

Governance Body required assurance on the AF and RR rather than looking at the documents in detail. Authority had therefore been devolved to the IGAC to undertake more detailed scrutiny, whilst informing the GB at high level.

Review of the Risk Management (RM) Policy highlighted that the corporate objectives stated were not in line with those included with the CCG's Five Year Strategy (2014/15 to 2018/19) which was approved by the GB at the start of the financial year. Further observations were made in regards to the content of the report, such as the lack of guidance on the purpose of the report, the CCG's risk appetite and objectives of risk management

Following our review, Governance and Business processes directorate have:-

- *Enhanced the Assurance Framework, which was presented to November IGAC.*
- *Have updated Risk Management Strategy, including formal process with partnering organisations and was presented to March IGAC.*

RANGE OF INDIVIDUAL OPINIONS ARISING FROM RISK-BASED AUDITS IN THE YEAR

At time of reporting we had completed and reported on eight audit areas, five financial and three governance topics.

Reasonable Assurance was provided for all topics, except one where substantial assurance was provided. There were no audits during the year that were given the lower assurance levels of limited or no assurance.

Detail on all completed audits has been reported to the CCG Integrated Governance and Audit Committee during the year, through Internal Audit Progress Reports, and has been summarised in the 2014/15 Internal Audit Annual Report, including key issues that were identified during the course of our work in 2014/15.

Two audits included in the 2014-15 areas were in progress at the year-end, Safeguarding Adults and Critical Finance Review on pooled budgets. These have been excluded from the overall opinion and will be reported in 2015-16.

RELIANCE PLACED UPON THIRD PARTY ASSURANCES

Reliance was not placed on any third party assurances.

Data Quality

Acute Sector

There have been some major issues with data quality for specific providers such as Royal Berkshire Hospital Trust. This has been address as part of the contract management and penalties applied. Quality has improved in 2014 / 2015 although full resolution will take a few months. CSU colleagues are working with the provider on an on-going basis and developing reporting strategies to mitigate the impact on reporting.

Changes in specialist commissioning rules in 2014 / 2015 compared to 2013 / 2014 are causing further problems. Whilst OUHT data quality in year is excellent (and monitored as part of the contract), applying the new rules to 2013 / 2014 data to present year on year growth is still problematic. CSU colleagues are working on resolving the issues.

Non Acute

Availability of data for the non-acute sector is increasing at speed. However, knowledge of these datasets and data quality processes are not yet as well established as they are in the acute sector. As a consequence, potential quality issues are less well understood. This impacts our commissioning ability but does not significantly impact in year financial risk. This is because of the extensive use of block contracts.

During 2014/ 2015 OCCG was in negotiation with OHFT and its partner organisations to develop a new outcomes based contract for the provision of mental health services.

Business Critical Models

OCCG does not own or has not developed any business critical models that have supported its planning in 2014/15. Our CSU 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 the CCG.

Data Security

We have submitted a satisfactory level of compliance with the information governance toolkit assessment. An action plan was developed to raise our level of compliance with the toolkit which was reviewed monthly at the IG Steering Group. The Information Security Assurance plans were reviewed and a formal risk assessment for key information assets was undertaken – particularly those in the CSU where the major information assets are held.

There have been 5 data breaches during 2014 / 2015 none of which have needed reporting to the Information Commissioners Office. All breaches have been investigated with actions and lessons identified and implemented.

We have had no serious incidents requiring investigation relating to data security breaches, including any that were reported to the Information Commissioner.

Discharge of Statutory Functions

During establishment, the arrangements put in place by the clinical commissioning group and explained within the *Corporate Governance Framework* were developed with extensive expert external legal input, to ensure compliance with all the relevant legislation. That legal advice also informed matters reserved for Governing Body decision and the scheme of delegation.

In light of the 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 these 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.

Conclusion

No significant internal control issues have been identified.

David Smith

Accountable Officer

[x] May 2015

Tables of attendance for Governing Body and Committee Meetings

Membership is in line with constitution dated January 2015

Governing Body

Name	29/05/14	31/07/14	25/09/14	27/11/14	29/01/15	26/03/15
Joe McManners	✓	✓	✓	✓	✓	✓
David Smith	N/A	✓	✓		✓	✓
Ian Wilson	✓	N/A	N/A	N/A	N/A	N/A
Louise Wallace	✓	✓			✓	✓
Stephen Attwood	✓	✓	✓	✓	✓	✓
Andrew Burnett		✓	✓		✓	✓
Paul Park	✓	✓		✓	✓	✓
Gareth Kenworthy	✓		✓	✓	✓	✓
Mary Keenan		N/A	N/A	N/A	N/A	N/A
Graz Luzzi	✓	✓		✓	✓	
Sula Wiltshire	✓	✓	✓	✓	✓	
Gina Shakespeare	✓	✓	✓	N/A	N/A	N/A
Diane Hedges	N/A	N/A	N/A	✓	✓	✓
Miles Carter	✓	✓		✓	✓	✓
Julie Anderson	✓	✓	✓	✓	✓	✓
David Chapman	✓	✓	✓	✓	✓	✓
Roger Dickinson	✓	✓	✓	✓	✓	✓
Duncan Smith		✓	✓	✓	✓	✓
Fran Butler	✓		✓	✓	✓	✓
Catherine Mountford	N/A	N/A	✓	✓	✓	✓
Michael Delaney	N/A	N/A	N/A	N/A	N/A	✓
John Jackson	✓	✓	✓	✓		✓
Jonathan McWilliam		✓		✓	✓	

Finance and Investment Committee

Name	24/04/14	15/05/14	26/06/14	23/07/14	27/08/14	24/09/14
Stephen Attwood	✓	✓	N/A	N/A	N/A	N/A
Roger Dickinson	✓	✓	✓	✓	✓	✓
Mike Delaney	✓	✓		✓	✓	✓
Gareth Kenworthy	✓	✓	✓		✓	✓
Mary Keenan			N/A	N/A	N/A	N/A
Duncan Smith	N/A		✓	✓	✓	✓
Gina Shakespeare		✓			N/A	N/A
Diane Hedges	N/A	N/A	N/A	N/A	N/A	N/A
Julie Anderson	N/A	N/A	N/A	N/A	N/A	N/A

Name	22/10/14	20/11/14	18/12/14	27/01/15	19/02/15	17/03/15
Stephen Attwood	N/A	N/A	N/A	N/A	N/A	N/A
Roger Dickinson	✓	✓	✓	✓	✓	✓
Mike Delaney	✓	✓	✓		✓	✓
Gareth Kenworthy	✓	✓	✓	✓	✓	
Mary Keenan	N/A	N/A	N/A	N/A	N/A	N/A
Duncan Smith	✓	✓	✓	✓	✓	✓
Gina Shakespeare	N/A	N/A	N/A	N/A	N/A	N/A
Diane Hedges	✓				✓	✓
Julie Anderson	N/A	✓	✓	✓		

Integrated Governance and Audit Committee Attendance

Name	17/04/14	22/05/14	27/05/14	24/07/14	16/09/14	20/11/14	20/01/15	19/03/15
Ros Avery	✓		✓	N/A	N/A	N/A	N/A	N/A
Roger Dickinson	N/A	✓	✓	✓	✓	✓	✓	✓
Mike Delaney	✓	✓	✓	✓	✓	✓	✓	✓
Duncan Smith	N/A			✓		✓	✓	✓
Graz Luzzi	✓			✓	✓	✓	✓	✓
Catherine Mountford	N/A	N/A	N/A	✓	✓	✓	✓	✓
Sula Wiltshire				✓	✓	N/A	N/A	N/A
Gareth Kenworthy	✓	✓	✓		✓	✓	✓	

Quality and Performance Committee

Name	24/04/14	26/06/14	28/08/14	30/10/14	18/12/14	26/02/15
Louise Wallace	✓	✓	✓	✓	✓	✓
Sula Wiltshire	✓	✓	✓		✓	✓
Nick Elwig	□	□	N/A	N/A	N/A	N/A
David Chapman	✓	✓	✓		✓	✓
Diane Hedges	N/A	N/A	✓	✓	✓	✓
Catherine Mountford	✓	✓	✓	✓	✓	✓
Richard Green			✓	✓		✓
Julie Dandridge	✓	✓	✓	✓		✓
Tony Summersgill	✓	✓	✓	✓		✓
Gina Shakespeare	✓			N/A	N/A	N/A
Val Messenger		✓	✓	✓	✓	
Andrew Cooling			✓	✓	✓	✓
Cecile Coignet	✓					
Diana Roberts	✓	✓				
Hilary Seal						✓
Kate Gale						

Remuneration Committee Attendance

Name	13/05/14	29/05/14	04/07/14	27/11/14	24/12/14
Joe McManners	✓	✓	✓	✓	✓
Roger Dickinson	✓	✓	✓	✓	✓
Duncan Smith	✓		✓	✓	✓
Louise Wallace	✓	✓	✓		✓
Graz Luzzi	✓	✓	✓	✓	

OCCG Assurance Framework Executive Summary (in order of severity) 12 March 2015

Ref	Description	Likelihood	Current Mitigation
AF25 FIN	There is a risk that demands on the Oxfordshire Clinical Commissioning Group (OCCG) allocation exceed the available funding. As a result if demand and cost pressures exceed funding then the CCG will fail its in-year statutory financial duties and limit its ability for future sustainability and viability, which may also impact on providers and lead to a reduction in services	Init 20 | 2013-2014 | 2014-2015 | Acceptable residual risk 9 Manager: Gareth Kenworthy Opened: 10/02/2015 Target Date: 31/03/2016	The CCG has set what are considered to be affordable financial envelopes for its contracts with providers. Contract negotiation strategies will be progressed through negotiation meetings that seek to limit the CCG's exposure to demand/activity risk through robust demand/activity management (QIPP) plans, contractual arrangements and contingency reserves.
AF20 FIN	There is a risk that the different organisations within the health and social care system do not work together in a co-ordinated way for the benefits of patients and the most effective and efficient use of resources.	Init 16 | 2013-2014 | 2014-2015 | Acceptable residual risk 8 Manager: John Jackson Opened: 05/02/2015 Target Date: 29/01/2016	Establishment of the Systems Leadership Group to provide assurance that the system is working together. Creation of a Transformation Board and Joint Commissioning Board in March 2015. A Single Plan and a series of supporting plans will be developed by September 2015.
AF21 FIN	Significant transformational change will be required of the health and social care system in Oxfordshire over the next five years. There is a risk that this will not take place because individual organisations do not have the capacity to manage these changes or the resources to deliver them. In addition, there may be external challenges which make it more difficult to deliver those changes.	Init 16 | 2013-2014 | 2014-2015 | Acceptable residual risk 6 Manager: John Jackson Opened: 05/02/2015 Target Date: 31/03/2016	Transformation Programme and Transformation Board established March 2015. Transformation Team with seconded-in staff to be formed. Overview by the Systems Leadership Group will provide external challenge.
AF24 FIN	There is a risk that the Oxfordshire Clinical Commissioning Group (OCCG) does not (a) have and (b) use high quality business intelligence products to inform its decision making in performance management, change management and investment, which may result in sub-optimal decision making and subsequent impacts.	Init 16 | 2013-2014 | 2014-2015 | Acceptable residual risk 8 Manager: Gareth Kenworthy Opened: 10/02/2015 Target Date: 31/03/2017	The CCG has an approved Business Intelligence Strategy. This now needs to be developed into a programme for delivery. The strategy has been shared with the CSU (as our Business Intelligence delivery partner) to inform the direction or work under our contract. NHS standard contract information schedules are being reviewed through contract negotiations to get closer alignment to the strategic objectives where possible. The CCG Organisational Development programme has been developed to reflect Business Intelligence requirements.

Ref	Description	Likelihood	Current Mitigation
AF19 QPC	There is a risk that the range of current performance challenges will affect the Oxfordshire Clinical Commissioning Group's (OCCG) ability to deliver NHS Constitution pledges and optimum care pathways, in particular A&E waiting times, Cancer waiting times, Referral to Treatment Time (RTT) in 18 weeks and Delays in Transfer of Care (DTOC); this may lead to poor patient experience, reduced confidence in the NHS and incur additional financial pressure.	Init 16 · 2013-2014 · 2014-2015 · Acceptable residual risk 12 Manager: Diane Hedges Opened: 10/02/2015 Target Date: 29/05/2015	SRG overseeing recovery plans on DTOC, including escalated 4 week reduction and Planned Care recovery process, covering Cancer, 52 week waits and the 18 week pathway. Weekly teleconference review of all Urgent care actions and strengthening contractual oversight in OUHT
AF23 FIN	There is a risk that demand for health and social care services exceeds capacity in the Oxfordshire system leading to a failure of national performance requirements.	Init 16 · 2013-2014 · 2014-2015 · Acceptable residual risk 12 Manager: Diane Hedges Opened: 10/02/2015 Target Date: 30/09/2015	Analyse and understand root causes in demand experienced in 2014/15 and enable the system to respond to further anticipated rises. Re-designing care pathways to manage patients needs at the most appropriate skill level. Ensure sufficient primary care capacity to manage urgent and overflow requirements. Designing quality and safety mechanisms to assure that overcrowding is not generating inappropriate patient risk.
AF18 FIN	There is a risk that the primary care transformation required to link in with new models of care will not be delivered leading to continued pressures on the current services and sub-optimal care for patients.	Init 12 · 2013-2014 · 2014-2015 · Acceptable residual risk 9 Manager: John Jackson Opened: 10/02/2015 Target Date: 29/05/2015	OCCG Governing Body has approved co-commissioning with NHS England. A number of funding bids to support capacity and infrastructure within primary care were prepared for submission during February 2015, to enable the expansion of out-of-hospital services.
AF22 QPC	There is a risk that the Oxfordshire Clinical Commissioning Group (OCCG) will not identify and rectify quality issues in provider organisations, resulting in sub-optimal care to patients, poor patient experience and a lack of clinical effectiveness.	Init 10 · 2013-2014 · 2014-2015 · Acceptable residual risk 5 Manager: Sula Wiltshire Opened: 09/02/2015 Target Date: 29/05/2015	OCCG has received a wide range of information relating to the quality of services in Oxfordshire and progress is being made in areas of poor performance.

OCCG Operational Risk Register (Red) Executive Summary (in order of severity) 12 March 2015

Ref	Description	Likelihood	Current Mitigation
735 QPC	There is a risk that the lack of a comprehensive system to manage test results at the OUHT will lead to delays in diagnosis and treatment.	Init 20 · 2013-2014 · 2014-2015 · Acceptable Residual Risk 4 Manager: Tony Summersgill Target : 30/04/2015 Opened: 29/07/2014	The Action Plan to improve systems using EPR has now been received. OCCG are to agree timescales and thresholds with OUHT. The Contract Query Notice remains open.
458 QPC	There is a risk that failure by OCCG to address 1) lack of resource in OUHT to answer appointment booking calls 2) poor capacity planning for elective treatment at OUHT 3) failure of OUHT to have effective systems to manage elective work will lead to delayed appointments and sub-optimal care for Oxfordshire's patients	Init 12 · 2013-2014 · 2014-2015 · Acceptable Residual Risk 4 Manager: Tony Summersgill Target : 31/03/2015 Opened: 16/12/2009	First Exception Report issued and a Remedial Action Plan for DBS (Direct Booking Service) with OUHT was agreed to roll out more specialities in Quarter three. DBS has been rolled out for ENT, Gynaecology, Urology and some smaller specialities in line with the agreed plan. There are currently no DBS indicators in the OUHT contract. KPIs (Key Performance Indicators) are to be developed and included in the 2015/16 contract.
702 QPC	There is a risk that GPs will be unable to manage patients adequately due to poor quality, inconsistent and delayed communications between primary and secondary care.	Init 16 · 2013-2014 · 2014-2015 · Acceptable Residual Risk 4 Manager: Tony Summersgill Target : 31/03/2015 Opened: 01/04/2013	There is a continued reduction in complaints received from GPs, demonstrating some improvement with Oxford Health Foundation Trust. Failure of OUH to provide consistent discharge summaries to GPs within 24 hours is a serious concern for the CCG. OUHT to use Electronic Patient Record (EPR) system to monitor the timeliness of in-patient discharge summaries as part of the 2015/16 contract. Roll out of electronic transfer of outpatient letters is on schedule.

Ref	Description	Likelihood	Current Mitigation
749 QPC	Inadequate clinical governance systems and administrative processes in Urology may lead to poor management of test results, delays in appointments or failure to follow up patients within appropriate timescales	Init 16 · 2013-2014 · 2014-2015 · Acceptable Residual Risk 4 Manager: Tony Summersgill Target : 31/03/2015 Opened: 13/01/2015	Regular meetings are in place between the CCG and Urology. A Urology Action Plan is in place, but does not appear to be improving current systems.
758 QPC	Non delivery on the 50% plan could result in greater external scrutiny of the Oxfordshire System and damage to reputation as a result. The risks relate to the investment of significant resources and clinician/manager time into a short term scheme, and consequences if the project does not deliver the anticipated benefits, or if the project delivers only to return to the pre-plan situation once the project stops.	Init 20 · 2013-2014 · 2014-2015 · Acceptable Residual Risk 8 Manager: Alison Edgington Target : 31/03/2015 Opened: 10/02/2015	50%DToC Plan based on the broader and established Oxfordshire DToC Plan which has been designed to deliver a longer term sustainable result. Steering group and key leads identified for the plan. Mechanisms in place to monitor performance and amend the 50% plan in real time as appropriate
716 FIN	There is a risk that due to high levels of activity within AQP providers, where there is no method in place to cap activity or adjust nationally set contracts spending, the AQP system will become unsustainable leading to budgetary pressures for the CCG across the term of the contract	Init 12 · 2013-2014 · 2014-2015 · Acceptable Residual Risk 6 Manager: Sharon Barrington Target : 31/12/2015 Opened: 13/05/2013	Work is on- going with OH to ensure activity stays level for Podiatry which is currently performing within budget. AQP audiology continues to be overspent. A review of audiology by Monitor was published on 5th March 2015, and this will inform further work to reduce AQP costs. This also forms part of a Business Case for ENT & Audiology which is due to be presented to the Programme Management Board at a future date.