Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Board Meeting

Date of Meeting: 25 May 2017	**Paper No: 17/34**

Title of Paper: OCCG Annual Report

Paper is for: (please delete tick as appropriate)	**Discussion**	✓	**Decision**	✓	**Information**	✓

Purpose and Executive Summary:
The following paper includes the Performance Report and the Accountability Report sections of the Annual Report for 2016/17.

The Performance Report must consist of:

- An summary that provides the public with information to understand the organisation, its purpose, key risks, objectives, achievements and how it has performed in the year.
- A Performance analysis – to report on the organisations most important performance measures.

The Accountability Report must consist of:

- A Corporate Governance Report
- A Remuneration and Staff Report
- A Parliamentary Accountability and Audit Report

Financial Implications of Paper:
Not applicable

Action Required:
To agree the report

OCCG Priorities Supported (please delete tick as appropriate)	
✓	Operational Delivery
✓	Transforming Health and Care
✓	Devolution and Integration
✓	Empowering Patients
✓	Engaging Communities

✓	System Leadership

Equality Analysis Outcome:
Not applicable.

Link to Risk:
The Annual Report covers the business of OCCG and will link to all risks on the Strategic Risk Register and Red Operational Risk Register.

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Date of Paper: 17 May 2017

NHS
Oxfordshire
Clinical Commissioning Group

NHS Oxfordshire Clinical Commissioning Group: Annual Report 2016/17

Contents

PERFORMANCE REPORT

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

'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.'

Oxfordshire Clinical Commissioning Group's vision and mission statement

Performance Overview

Oxfordshire Clinical Commissioning Group

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

These services include hospital services, mental health services, GP services, community services such as district nursing and physiotherapy. We do this on behalf of people registered at GP practices in Oxfordshire and those who live in Oxfordshire (but not registered with a GP practice). To do this successfully, we work with local people, GPs, pharmacists, optometrists, dentists, hospitals and other partners including local government and the voluntary sector. OCCG is a member organisation of 72 GP practices in Oxfordshire.

Part of the National Health Service Act 2006 (as amended) 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 (HWB) Strategy.

This Annual Report illustrates how we comply with the Act. Oxfordshire has a HWB strategy which is a joint strategy designed to improve the health and wellbeing of local people and reduce health inequalities[1] across the county. OCCG is a member of the Health and Wellbeing Board which monitors the delivery of the strategy.

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

OCCG's work is guided by our Five Year Strategic Plan, 2014/15 – 2018/19, which directly supports delivery of the HWB strategy. It was developed in 2014 with input from the public and our partners.

Further to this, OCCG with our NHS and social care partners have embarked on a programme of change for health and social care to ensure the people of Oxfordshire have the very best standards of care across the county.

In 2015, a Transformation Board was formed to oversee this system wide change programme. It comprises OCCG, Oxford Health NHS Foundation Trust (OHFT), Oxfordshire University Hospitals NHS Foundation Trust (OUHFT), South Central Ambulance NHS Foundation Trust (SCAS), Oxfordshire County Council (OCC) and the Oxfordshire Primary Care Federations. Its joint purpose is to develop plans for integrated GP, community, hospital and social services across Oxfordshire and ensure health services are sustainable for the future and provide effective care (see page 15).

Oxfordshire's Population[2]

As a whole people living in Oxfordshire enjoy a relatively good quality of life with higher than average earnings and low rates of unemployment compared with many other parts of the country. The population has grown by more than 10% in the last 15 years and it is expected to continue growing, due to increases in life expectancy and more people moving into the county.

Most people in Oxfordshire are from White British or Irish backgrounds and the county is becoming more ethnically diverse. There are large differences between districts: just under two thirds of Oxford City's population was White British or Irish compared with more than nine in ten for three other districts: West Oxfordshire, South Oxfordshire and Vale of White Horse.

Overall, Oxfordshire has relatively low levels of multiple deprivation. It is the 11th least deprived of 152 upper tier local authorities in England (up from 12th least deprived in 2010). However, there is significant variation across different parts of the county.[3]

Two areas in Oxfordshire are among the 10% most deprived in England. These are in Oxford City, in parts of Rose Hill and Iffley ward, and Northfield Brook ward. In 2010 only the latter of these was among the 10% most deprived areas nationally. A further 13 in the county areas are among the 10-20% most deprived (down from 17 in 2010). These are concentrated in parts of Oxford City, Banbury, and Abingdon. Deprivation has important implications for health, with marked health inequalities between the least deprived and most deprived areas.

[2] Oxfordshire Joint Strategic Needs Assessment 2016

[3] The English Indices of Deprivation 2015 are based on 37 indicators spanning seven broad types of deprivation. These indicators are used to calculate an overall Index of Multiple Deprivation (IMD). The IMD is a key single measure of multiple deprivation experienced by people living in English neighbourhoods.

Oxfordshire remains a relatively rural county. At the time of the 2011 Census, around two thirds of Oxfordshire's population lived in an urban area (66.6%) and a third lived in a rural area (33.4%). This compares to proportionately larger urban populations in the south east (79.6% of the total population) and England overall (82.4%).

Levels of disability are low in Oxfordshire, compared to national averages, but around 90,000 residents report being limited in their daily activities.

Oxfordshire's residents tend to be relatively healthy compared with other parts of the country. Common conditions experienced by residents include high blood pressure, diabetes, asthma and mental health disorders like depression and anxiety – this is similar to areas across England.

The leading causes of death in Oxfordshire are dementia (for women) and heart disease (for men). Whilst levels of excess weight are relatively low in Oxfordshire, around three in five adults, and over a quarter of Year 6 children (aged 10 -11), are overweight or obese. Physical activity levels are high relative to other areas nationally, with 63.1% of adults achieving the recommended 150 minutes of exercise per week. An estimated 13.6% of adults and 10.4% of 15 year olds in Oxfordshire smoke.

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

Overview of Performance from David Smith – Chief Executive

During 2016/17, OCCG has focussed on a long term change programme to tackle the many challenges facing the NHS; in addition to the 'everyday' work of ensuring current services are of the highest quality. Over the past year we have seen real improvements in patient care and have made significant in-roads into developing a stable and sustainable NHS in Oxfordshire.

Like many areas across England, Oxfordshire is facing unprecedented demand on its services. We have a growing number of older people living in the county, many of whom are living with long term chronic conditions. At the same time more people are moving into the county and we are facing real challenges recruiting high quality NHS staff and maintaining high quality buildings and facilities.

While the amount of money we receive for the NHS locally is increasing year on year, the cost of delivering services is growing at a faster rate. If we don't change anything, we face a potential funding gap of £134m by 2020/21 across the NHS in Oxfordshire.

A considerable amount of work has been undertaken with clinicians and members of the public, as part of our change programme, to see how we can change healthcare services making them sustainable and affordable for the future. This work has included

clinical reviews of many services across Oxfordshire and discussion with our local communities and resulted in a public consultation which started in January 2017.

OCCG held 15 public events through the consultation and spoke to more than 1,300 people across the county; over 500 people responded to our survey and we received more than 9,000 letters and emails. The report on the consultation will be published in June 2017, followed by final proposals and decisions being made by OCCG Board in the summer.

This work contributes to Oxfordshire part of the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation Plan (STP) which is a place-based, strategic plan demonstrating how, as a health and social care system we will close the care and quality gap and unlock resources to invest in meeting future demand. As Chief Executive of OCCG I lead the BOB STP programme of work which includes local authorities, NHS provider trusts and clinical commissioning groups across Buckinghamshire, Oxfordshire and Berkshire West.

In April 2016 the Oxfordshire Health Inequalities Commission[4] launched its enquiries with an inaugural meeting at Rose Hill Community Centre in Oxford to look at the theme of 'ageing well'. It was part of a series of meetings organised by the commission, which was set up with the support of OCCG, to look at ways achieving sustainable reductions in health inequalities in the county. The Commission published its findings in November 2016; these are being used to inform our change programme.

While we have seen significant improvements in planned care, we have struggled to meet our constitutional targets for patients being referred and treated within 18 weeks - this continues to be a challenge. However, we have launched a new Minor Eye Care Service which is provided at local optometrists and helps to alleviate pressure on outpatient appointments at our local hospitals. We have also further developed an 'advice line' between GPs and hospital consultation which gives GPs direct access to hospital consultations for advice on diagnosis and treatment of patients, reducing the need for hospital appointments and enabling patients to be treated in the community.

We have launched a number of initiatives to help alleviate pressure on urgent care services[5] this year. In June 2016, we launched the 'Health and Care Oxfordshire' smart phone app to signpost people to the most appropriate health service if they felt ill or needed treatment. The free device which can be downloaded from Android and iphone app stores uses the latest technology including digital maps to locate precisely GP practices, hospitals and minor injury and first aid units in the county, and adult social care support, so people can access these services quickly.

[4] Health Inequalities Commission was set up to gather evidence and make recommendations for reducing health inequalities in Oxfordshire. Its members included an independent chair and members from statutory, voluntary and academic organisations. OCCG's Clinical Chair was a member.

[5] Urgent care services are services that provide care for people with injuries or illnesses requiring immediate care. This can include GP out of hours services, minor injury units and walk-in centres and accident and emergency departments.

Other initiatives included new ambulatory assessment units at both the Horton General Hospital and the John Radcliffe Hospital. These units assess and treat patients on a day case basis to reduce the need for patients to be admitted to hospital. We also launched a similar service at the new Townlands Memorial Hospital with a Rapid Access Care Unit opening in January 2017 to provide assessment and treatment of patients with a crisis or deterioration in their health. Whilst we have failed to reach our Accident and Emergency (A&E) target to see, treat and either discharge or admit patients within four hours; 96.6% of people attending one the three minor injury units in the county within the four hour timeframe.

Improving the quality of services provided in Oxfordshire and outcomes for people is a major part of our work. We continue to monitor our services to ensure we can act when things are not working well. Our work was recognised in the summer last year when OCCG's Quality team was shortlisted for a Health Service Journal Patient Safety Award for Preventing Avoidable Harm.

We also began a 'mystery shopper' campaign in May 2016 to gather people's views of using local health services to help identify areas that could be improved. This initiative, which was set up in partnership with the Patients Association, recruited patients to get their feedback straight after a hospital appointment they had attended or treatment they had received. The project included patients using the John Radcliffe, Churchill and Horton General hospitals and the Nuffield Orthopaedic Centre.

We are in the second year of a seven year outcomes based contract for adults with mental illness. The services provided through this new type of contract aim to improve mental health outcomes for adults, bringing together in-patient, community psychiatry and psychology, housing and support, recovery services, employment support and a wellbeing service. We were delighted to be recognised for this work when we won a 'Healthcare Transformation Awards' in July 2016 for the new contract and services was judged the best entry in the category *'commissioning for outcomes and reducing variation'*.

OCCG took over the commissioning of services for people with learning disabilities from Oxfordshire County Council in July 2016. Work also continues to ensure a safe transition of services for people with learning disabilities currently provided by Southern Health NHS Foundation Trust to Oxford Health NHS Foundation Trust by the end of 2017.

In 2016/17, OCCG took on formal delegated responsibility from NHS England for GP Primary Care Commissioning and has received a transfer of allocation of £91m in order to deliver this. This significant increase in our funding for 2016/17 did not remove the need for us to identify and implement initiatives that improve the efficiency and value for money of all our healthcare services.

We have continued to work with our GP and member practices to support the numerous services set up through the Prime Minister's Challenge Fund which have improved access for patients. We are experiencing staff shortages in general practice of up to

30%, due to an ageing workforce and difficulties in recruiting younger GPs to replace those retiring. Recognising this, we have supported some practices with additional practice manager input to help address issues of workforce pressures and financial processes.

OCCG was given early access to new funding (GP Access Fund) which we invested in additional primary care appointments in the evening and at weekends. We have also funded the provision of an enhanced primary care service at Rose Hill Community Centre in Oxford, a neighbourhood among the 20% most deprived areas in England, to help address health inequalities.

We also remain in financial balance. We received £846m to purchase healthcare for the population of Oxfordshire in 2016/17. We started the year with a financial plan to reach £8.9m surplus by the end of the year and achieved a surplus of £12.9m (for more detail on this please see page 13). This additional surplus will be returned to us over the coming years which will help to tackle the financial gap we will experience over the next four years.

Managing Risk

Reducing risk across the health system to ensure patients received high standards of care is a priority for OCCG. Risks are events or scenarios that can hamper OCCG's ability to achieve our objectives. These risks, divided into strategic and operation, are identified, assessed and managed by the organisation and reviewed at every OCCG Board meeting in public. They are continually reviewed at Board sub-committee meetings including the Audit Committee, the Finance Committee, the Oxfordshire Primary Care Commissioning Committee and the Quality Committee. In addition to the above sub-committees, OCCG directors review all risks in the directors' risk review which is chaired by OCCG's director of governance. The report on OCCG's strategic and operational risks as of 31 March 2017 can be found on OCCG website here.

The table below outlines OCCG's principal risks (those strategic risks that are classed as at extreme risk, showing mitigating measures as at 31 March 2017; further information is available at the above link:

Risk	Mitigation
There is a risk that OCCG will not be able to meet the NHS constitutional standards due to performance issues and demand for services leading to poor patient experience and outcomes	An A&E Delivery Board action plan is in place; it has Executive Leads identified to be responsible and to report on the different workstreams of the plan including delayed transfers of care. Additional resources are being sourced from NHS England to give extra capacity. As a result of the plan there has been improvement in A&E to 90% in the 4 hour target.
There is a risk that the sustainability of primary care services will adversely impact on the delivery of the wider health	There has been investment of £4m to primary care to support its sustainability. Each Locality is using the investment to

system and will impact the care received by patients	best support local need. (More information on this investment is available on page 13). Developing sustainable primary care services is being considered as part of the Oxfordshire Transformation Programme within the second phase.
There is a risk that the different organisations within the health and social care system do not work together efficiently and effectively for the benefit of patients and the efficient use of resources.	Health and Social care organisations are working together in partnership through the Chief Executive System Delivery Board and the Oxfordshire Transformation Board to ensure alignment of planning; to agree and implement together an overarching transformation programme to manage future demand and financial pressures.
There is a risk that NHS services will not be able to respond to the anticipated level of demand over the next 5 years and the challenges in the 5 Year Forward View leading to risks in the quality and safety of clinical care and financial sustainability across the Oxfordshire health system and at Buckinghamshire, Oxfordshire and Berkshire West level.	Phase one of the Oxfordshire Transformation Programme has been assured by NHS England and a public consultation has been completed. The results of the consultation will be considered by the CCG in June 2017. New Governance arrangements are in place to oversee the development of Phase Two which includes a Finance Working Group, Communication & Engagement Group and Clinical Working Groups. These groups report to a new Programme Executive who make recommendations to OCCG Board on the Transformation plans.
There is a risk that demands on 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.	OCCG delivered its 2016/17 financial plan following contract settlements and the delivery of an in-year financial recovery plan to mitigate cost pressures. Contract negotiations for 2017/18 have concluded with OUHFT, OHFT with an agreement which includes a three way risk share and proposals for risk management and mitigation.
There is a risk that OCCG will not identify and rectify healthcare quality issues in Oxfordshire, resulting in sub-optimal care to patients, poor patient experience and lack of clinical effectiveness.	OCCG receives a wide range of information relating to the quality of services in Oxfordshire and some progress is being made in areas of poor performance. The Care Quality Commission's inspection of SCAS and OHFT have resulted in overall ratings of 'Good' for both organisations. Phase 2 of the Mazars Report is progressing.

Performance Analysis

How do we monitor performance?

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

OCCG has formal committees of the Board which scrutinise how OCCG and our health providers are performing; these are the Finance Committee, the Audit Committee, Oxfordshire Primary Care Commissioning Committee and the Quality Committee (for more information about the committees and their purpose please see page 51.

In addition to the monitoring requirements outlined above the Accident & Emergency (A&E) Delivery Board also has a role to play in monitoring performance. It members include the chief operating officers from NHS organisations in Oxfordshire. The group aims to develop and maintain resilience across the urgent care services, and improve the flow of patients through A&E, admission, treatment and discharge. It looks at Oxfordshire health and social care as whole from primary care to community and hospital care, whether statutory or independent; and will offer input to achieve its aims.

Performance against NHS Constitution Targets

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

Category	Indicator	Target	OCCG Achieved (2016/17)
Referral to Treatment waiting times for non-urgent consultant led treatment	Admitted and non-admitted patients to start treatment within a maximum of 18 weeks from referral	92%	**90.7%**
Cancer Waiting Times	Maximum two week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP.	93%	**93.3%**
	Maximum two week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	**92.2%**

Cancer Waiting Times	Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers		96%	**95.6%**
	Maximum 31 day wait for subsequent treatment where that treatment is surgery.		94%	**96.2%**
	Maximum 31 day wait for subsequent treatment where the treatment is an anti-cancer drug regimen.		98%	**99.5%**
	Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy.		94%	**95.9%**
	Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer		85%	**78.1%**
	Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers.		90%	**95.3%**
Diagnostic test waiting times	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral		1%	**Data to follow**
A&E Waits	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	OUHFT	95%	**86.1%**
		RBFT	95%	**92.3%**
		OHFT	95%	**96.6%**
	The number of patients waiting longer than 12 hours on a trolley		0	**0**
			0	**0**

Category A Ambulance Calls	Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	75%	70.4%
	Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	75%	71.7%
	Category A calls resulting in an emergency response arriving within 19 minutes	95%	92.9%
Mixed Sex Accommodation Breaches	Breaches of same sex accommodation	0	65
Cancelled Operations	All patients who have operations cancelled on or after the day of admission (including the day of surgery), for non-clinical reasons, to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.	0	**Data to follow**
Mental Health	Dementia Diagnosis	67.7%	67.7%
Delayed Transfers of Care	Number of days delayed as % of occupied bed days	3.5%	**Data to follow**

How we manage our money

OCCG's total funding for the financial year 2016/17 was £846m, of which £831.4m was allocated for healthcare programmes and £14.6m for running costs of the CCG. 2016/17 was the first year that OCCG took formal delegated responsibility from NHS England for GP Primary Care Commissioning and received an allocation of £91m in order to deliver this. In setting our financial plans at the start of the year we complied with all planning requirements and agreed with NHS England to deliver £4m in addition to the target 1% surplus of £8.9m i.e. £12.9m in total. This additional surplus carried forward will be drawn down by the CCG over the next 4 years, helping to smooth out the lower allocation growth increases from 2017/18 to 2020/21.

As set out in the 2016/17 NHS Planning Guidance, CCGs were required to hold a 1% reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be

released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs' 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS Oxfordshire has released its 1% reserve to the bottom line, resulting in an additional surplus for the year of £8.2m. The CCG reported surplus therefore rose from £12.9m to £21.1m. This additional surplus will be carried forward for drawdown in future years.

Below outlines budget and spend for 2016/17:

	Annual Budget £'000	Actual Month 12 £'000	Variance Month 12 £'000
Acute	400,607	403,386	2,779
Community Health	70,637	70,999	362
Continuing Care	57,934	64,851	6,917
Mental Health and Learning Disability	68,439	68,922	483
Delegated Co-Commissioning	89,546	89,012	(534)
Primary care	100,516	97,659	(2,857)
Other Programme	16,355	15,793	(562)
Sub Total Programme costs	**804,034**	**810,622**	**6,588**
Running costs	14,642	14,207	(435)
Sub Total	**818,676**	**824,829**	**6,153**
Transformation/risk management	0	0	0
Non recurrent reserve	8,198	0	(8,198)
Contingency	6,161	0	(6,161)
1% Surplus	12,924	0	(12,924)
Total	**845,960**	**824,829**	**(21,131)**

The plan for 2016/17 was to agree a lead provider arrangement with our main acute and mental health/community providers but this proved not to be deliverable, instead block contract arrangements were agreed during the year. However for 2017/18 new risk sharing agreements are in place.

During 2016/17, OCCG has continued with joint commissioning and pooled budget arrangements with Oxfordshire County Council for Older People, Physical Disability, Learning Disability and Mental Health. The Better Care Fund of £35.0m forms part of the Older People's pool. The pool arrangements will be reviewed in 2017/18 to ensure the pool structures best underpin the outcomes that both parties wish to achieve.

For the financial year 2017/18 we will receive a £16m increase to our funding compared to £50m in 2016/17. The CCG will remain at 4.8% below target funding.

There remains a need for OCCG to identify and implement initiatives that improve the efficiency and value for money of our healthcare services. As a result, we have targeted a savings plan of £20m for 2017/18. Savings will be delivered in the following areas: Right Care[6], demand management, operational changes, service redesign as well as system transformation.

The key risk for OCCG moving forward into 2017/18 remains the same as it is for all NHS organisations across the country, which is to address the increasing demand for NHS services within the resources available.

Changing healthcare in Oxfordshire

The NHS in Oxfordshire performs well compared to other parts of the country. However, like the rest of the country, the current health and social care system faces a number of challenges.

Changes in people's health and longer life expectancy mean that the county's health services are facing demand on a scale not seen before. In addition, those people living in Oxfordshire's most deprived communities often experience more ill health and worse outcomes than people living in more affluent areas.

One of the greatest challenges for Oxfordshire's health and care system is our ability to attract, recruit and keep skilled and motivated staff in the numbers we need. This is not a challenge unique to Oxfordshire and is shared by most other areas of the country.

The challenges we face include:

- staff shortages in general practice of up to 30% (due to an ageing workforce and difficulties in recruiting younger GPs to replace those who are retiring)
- the challenge of being close to London and the high cost of living in Oxfordshire, both of which can mean other areas are more desirable to work in
- competition with other businesses, given Oxfordshire's high level of employment
- a high turnover rate of support workers who look after people in their own homes and in care homes, with a very large number of vacancies at any one time
- a national shortage of a wide range of staff including people working in emergency care, intensive and critical care, stroke care, radiography, obstetrics and paediatrics.

As a result, many of our health services rely on using expensive agency and temporary staff to keep services going. This increases pressure on finances that are already stretched.

The overall quality of health services provided in Oxfordshire is good. However, there are some aspects of care that must be improved. We need to do more to make sure that all patients receive care which meets national standards (for example waiting times

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

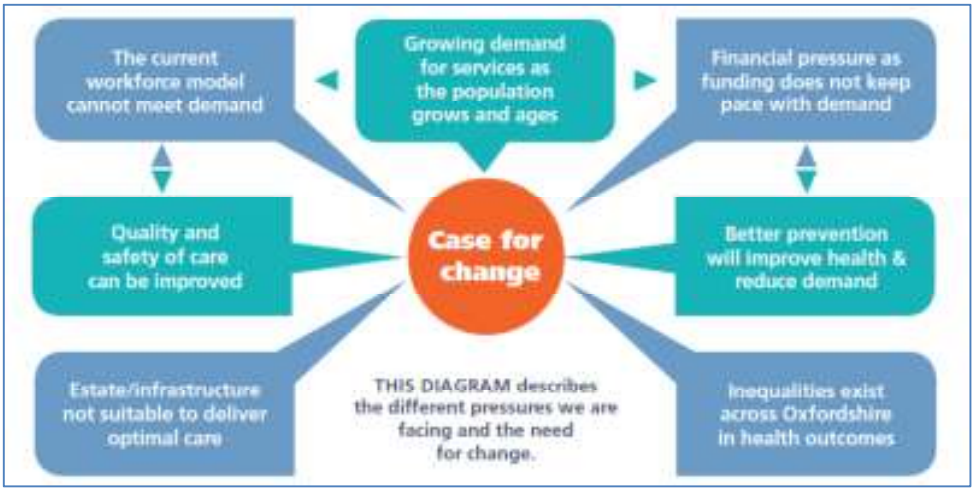
for treatment). Some of our buildings and equipment are old and not fit for providing modern care. Some of them are also expensive to run and need to be replaced or improved.

While the amount of money received for the NHS locally is increasing year on year, the cost of delivering services is growing at a faster rate. The local NHS needs to be able to cope with the significant increase in activity within the budget available – it is anticipated that over the next four years there will be a gap in funding of £134million.

The Oxfordshire Transformation Programme (OTP) was established to bring NHS partners together to address these concerns and ensure that the people of Oxfordshire have the very best standards of care across the county. The OTP has already carried out a clinical review of services across the county with a particular focus on:

- Maternity and children's services
- Learning disability, adult mental health and autism services
- Planned care
- Urgent care
- Community services including community hospital
- Primary care

Below outlines our case for change for the progamme:



Across the NHS in Oxfordshire we have an agreed vision for how we want to improve our services:

- The best quality care provided to patients as close to their homes as possible.
- Health professionals, working with patients and carers, with access to diagnostic tests and expert advice quickly so that the right decision about treatment and care is made.
- As modern Healthcare develops, ensuring our local hospitals keep pace, providing high quality services to meet the changing needs of our patients.
- Preventing people being unnecessarily admitted to acute hospitals or using A&E services because we can't offer a better or more local alternative.

- The best bed is your own bed – people recover better at home with the right support.

In addition to the care and treatment provided when we become ill, there is more we can all do to keep healthy. This includes making healthy lifestyle choices, managing long term conditions and looking after ourselves when we become unwell with minor conditions. Preventing people from becoming unwell and supporting them to adopt healthier lifestyles is a key part of our Transformation Programme.

In June 2016 Oxfordshire's NHS embarked on 'The Big Health and Care Conversation' with the public. We asked the public's views on the developing case for change and how care could be delivered differently while still providing the best care, the best health outcomes and the best value for people living in the county.

Towards the end of last year it became clear that the emerging proposals for some services being reviewed (urgent care, children's services and community-based care - including community hospitals and primary care) would benefit from continued development with a wide range of stakeholders before a public consultation on any proposed service changes. As such the OTP and consequently the consultation have been split into two phases.

The areas that are being looked at in the first phase are those that require immediate resolution because of safety and quality issues for patients. This consultation started on 16 January and ran for 12 weeks. The first phase is looking at acute hospital services, specifically,

- Changing the way we use our hospital beds and increasing care closer to home in Oxfordshire
- Planned care at the Horton General Hospital (planned care includes tests and treatment planned in advance and not urgent or emergency care)
- Stroke services in Oxfordshire
- Critical care (critical care helps people with life-threatening or very serious injuries and illnesses) at the Horton General Hospital
- Maternity services at the Horton General Hospital including obstetrics and the Special Care Baby Unit (SCBU).

Phase 2 consultation will focus on:

- Acute hospital services:
    - Urgent care in Oxfordshire
    - Children's services
- GP and Community services including community hospitals and Midwifery Led Units

For more information about the OTP and the consultation please visit: http://www.oxonhealthcaretransformation.nhs.uk/

Oxfordshire together with Buckinghamshire and Berkshire West (BOB) health and social care systems have developed a 5-year Sustainability and Transformation plan

(STP).The STP is a place-based, strategic plan demonstrating how, as a health and social care system, we will:

- Close the health and wellbeing gap
- Drive transformation to close the care and quality gap
- Unlock resources of around £176m to invest in meeting the challenges of future demand, while achieving and maintaining financial balance, while still delivering on the first two

The Oxfordshire Transformation Programme is part of the BOB STP it is not separate. Our change programme is the Oxfordshire 'chapter' of the BOB STP with common pieces of work across all of the geographical areas such as developing a sustainable workforce.

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

It is recognised, nationally and locally, that primary care, in particularly general practice is under pressure. This is due to an increasing workload from patient demand and complexity of illnesses and conditions, with many GPs working increasingly long hours. In the next five years 30% of GPs plan to retire in Oxfordshire whilst the numbers of trainees wanting to work as GPs or practice nurses is declining. This is leading to problems with patients having difficulty accessing GP services as well as sustainability and workforce issues.

In 2016/17, OCCG took on formal delegated responsibility from NHS England for GP Primary Care Commissioning; OCCG recognises the extreme pressure that doctors are facing and is working with GP practices to look at ways to reduce this. Whilst recognising that short term solutions are likely only to have minor impact a number of initiatives and investments have been implemented during 2016.

The Prime Minister's Challenge Fund came to an end in March 2016. It had supported a number of initiatives to improve access for patients to GP services. OCCG invested money to support these initiatives whilst national guidance was developed into the next steps. OCCG continued to work with the GP Federations[1] in Oxfordshire, these are Abingdon Federation, OxFed, South East Oxfordshire Federation (SEOX) and Principal Medical Limited (PML[2]), to support the provision of:

- Care navigators – staff co-ordinating support for patients in their own home liaising with their GPs, families and carers in practices
- Email consultations between GPs and hospital consultants

[1] GP federations are groups of general practices or surgeries forming an organisational entity and working together within the local health economy. The remit of a GP Federation is generally to share responsibility for delivering high quality, patient-focussed services for its communities.

[2] PML – Principal Medical Limited is an umbrella organisation supporting four GP federations consisting of GP practices in the North (NOxMed), North East (OneMed), West (WestMed) and South West (ValeMed).

- Neighbourhood access hubs – urgent appointments for patients as an alternative to an appointment at their own GP surgery. In some areas, weekend appointments are available for more routine issues.
- Early visiting service - a team of emergency care practitioners working closely with GP practices and other community health and social care services. They carry out visits on behalf of GP practices, to elderly and housebound people in their own homes.

In April 2016, OCCG agreed an additional investment of £4million to support the sustainability and transformation of GP services. Each of our six localities in Oxfordshire prioritised the investment in order to best meet the needs of the local patients and practices. These included initiatives to enable practices to work at scale, enhance value for money, support the sustainability of General Practice and improve the ability to scale up services to absorb population growth where necessary

As a successful second wave site for the Prime Ministers Challenge Fund, OCCG was given early access to new funding (GP Access Fund) set up to provide additional primary care appointments in the evening and at weekends with some appointments available during normal hours. The extended access is mainly delivered through funding the local GP Federations, who in turn subcontract to practices where appropriate.

As stated previously deprivation in Oxfordshire is relatively low, but there is considerable variation across the county. In order to address some of these inequalities OCCG is funding the provision of an enhanced primary care service from Rose Hill Community Centre in Oxford. The aim of this service is to identify high risk adult patients with long term conditions and to target them with additional support from a team of GPs, specialist practice nurses and healthcare assistants, supported by other healthcare professionals including psychologists and physiotherapists where appropriate. It is hoped this approach will improve outcomes for a vulnerable group of patients in an area of particularly high deprivation. This service is due to start in June 2017.

As demand on GP services continues to increase, there will be a need for it to change and to encourage patients to self-care and access the health services at the most appropriate point. Along with GP colleagues, OCCG have developed a Primary Care Framework to provide strategic direction for a sustainable GP service in Oxfordshire. It forms part of the Oxfordshire Transformation Programme (see page 15) and describes a number of operational principles all of which will be important to the sustainability of GP care in the county. These include practices working together to share resources and share workload to provide a better service and manage demand; delivering care closer to home via a multidisciplinary neighbourhood team supported by a modernised IT system and investment in estates. See here for more details on the Primary Care Framework.

OCCG has visited GP practices that are vulnerable due to quality, financial or workforce issues and supported them to become more sustainable. We have a team of ten

experienced practice managers who can be deployed into a vulnerable practice to help identify and address issues such as workforce and financial processes. Where these Practice Managers have been working within an identified practice, feedback has been extremely positive.

There have been a number of closures and changes to GP practices in the County. North Bicester Surgery resigned their contract to provide primary medical care services in June 2016; OCCG worked with the practice to disperse the patient list to surrounding practices. Pressures at Kennington Health Centre also saw it merge with Botley Medical Centre at the end of March 2017.

Following an unsuccessful procurement process Deer Park Medical Practice in Witney closed on 31 March 2017. Its patient list was dispersed to surrounding practices. OCCG worked with the GP practice and its 4,399 patients to ensure that the list dispersal was managed in a safe and orderly way. We also worked with the other practices in Witney to help minimise any impact on their services as Deer Park closed.

In December 2016 a member of Deer Park Medical Practice Patient Participation Group requested a judicial review on the decision of OCCG to close services at Deer Park Medical Centre. The judge hearing the case in February 2017 refused permission to bring a judicial review, however the Oxfordshire Health Overview and Scrutiny Committee agreed to refer the matter to the Secretary of State for Health on the grounds that the closure was a substantive change in service. Subsequently the Secretary of State for Health referred the matter to the Independent Reconfiguration Panel[3]. An outcome is expected later in 2017.

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

Pressure on urgent care services across Oxfordshire including A&E and ambulance services has continued throughout 2016/17. There has been an increase in those attending A&E of 6.7% on last year and the complexity of patients has also increased. Whilst patient feedback from A&E services continues to be good we did not reach Government targets. 86.1% (for OUHFT against a target of 95%) of people attending A&E being seen, treated and either discharged or admitted within four hours at the end of March 2017. However this target was met within the minor injury units across Oxfordshire provided by OHFT with 96.6% being looked after in 4 hours.

A number of initiatives have started in the past year to reduce pressure on A&E including the introduction of a clinical coordination hub in October. Two 'ambulatory assessment units' have been set up in the John Radcliffe Hospital and the Horton General Hospital to assess and treat patients with complex needs around-the-clock. As a result, patients do not need to spend time in A&E or be admitted to an acute hospital

[3] The Independent Reconfiguration Panel is the independent expert on NHS service change. It reviews proposals for changes to NHS services that are being contested, and advise the Secretary of State for Health.

bed for overnight stays. The Emergency Multidisciplinary Units (EMUs) at Abingdon and Witney Community Hospitals also assess and treat patients on a same-day basis so they do not have to be admitted to a hospital bed, which is better for patients.

Similar to the EMUs a new Rapid Access Care Unit (RACU) at Townlands Memorial Hospital, in Henley on Thames, opened its doors to patients on the 23 January 2017. The RACU provides assessment and treatment of patients with a crisis or deterioration in their health. The service ensures patients can be assessed by a consultant and, if needed receive diagnostic tests or treatments such as intravenous antibiotics on the same day to help avoid a stay in an acute hospital. A patient who has attended the RACU may be discharged and continue to be treated in their own home or admitted to a RACU bed at the Chilterns Court Care Centre on the same hospital site.

Among the first patients at the RACU was an 83 year old lady who was delighted with the friendly, helpful service she received; saying the service was 'absolutely top class'. The new RACU has been positively received by the community generally.

This new model of care which helps to prevent admissions to hospital is key to reducing the number of people delayed in hospitals who no longer require acute medical support but need some sort of home care or rehabilitation in the community. Delayed transfers of care remain high within Oxfordshire with a weekly average of 133 people delayed across community and acute hospitals during 2016/17. This represents a reduction from the 2015/16 figure of 154. A number of initiatives that took place in 2015/16 have been extended: the development of a co-ordination hub to manage discharges and dedicated intermediate care beds to step down those people who are medically fit to leave hospital but not yet ready to go home. In addition, together with partners in the County Council and OHFT and OUHFT, we have

- Introduced new contracts for domiciliary care
- Developed and commissioned a new integrated discharge to assess service that provides assessment, reablement and short-term domiciliary care for people who are planned to return to their own home from hospital
- Developed a separate discharge to assess model for people who might be entitled to continuing healthcare so that their assessment does not need to take place in hospital

The position improved significantly in the first 6 months of 2016/17 with the average length of delay reducing and the length of delay also reducing significantly. Since then Oxfordshire has experienced similar problems to the rest of the country with a number of provider failures in the domiciliary care market and problems with recruiting workforce to the new integrated discharge to assess service. We are working now to improve the resilience of our domiciliary care and nursing home providers and create extra capacity and capability to manage more complex people outside of hospital.

One of OCCG's key aims over the next few years is to reduce the time patients spend in hospital for care in an emergency and increase care for people in the community or at home. Subject to the outcome of the transformation consultation (see page 39), we

plan to provide more diagnostics and outpatient care in community settings, away from hospitals and closer to where people live. The longer older people stay in hospital, the harder it is for them to recover and the risk of infection and loss of mobility increases: “10 days in a hospital bed is equivalent to 10 years lost muscle strength for people over 80 years old.” - British Geriatric Society.

Ambulance response times remain challenging across the County. SCAS has not achieved the 75% target of responding to category A calls within eight minutes (it reached XX% at year-end). The main initiative to improve response times being undertaken by SCAS is the National Ambulance Response Programme (NARP), which aims to support ambulance services to:

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

Getting the right treatment

In the past year, significant improvements have been made in planned care with many projects resulting in better local services for patients. A Minor Eye Conditions Service provided at local optometrists across the county enabling treatment for short term eye conditions such as red and dry eye, and visual disturbances, was launched in August 2016; the service has been popular with patients. It has been successful in reducing Eye Casualty appointments by providing a more convenient setting closer to home/work for patients.

OCCG also worked closely with GPs and hospital consultants to further develop an ‘advice line’, whereby GPs can email a hospital consultant for advice on diagnosis and treatment of patients, reducing the need for hospital appointments; this in turn helps relieve pressures currently felt at our hospitals. Interim evaluation shows that GPs are using the lines more frequently (just under 3,000 uses this year), and that 74% of queries through these ‘advice lines’ did not lead to a referral to a consultant with any treatment required provided by the GP. This is a real improvement – patients can be supported in primary care, saving patients and clinicians any unnecessary appointment at hospital and delay in their treatment and diagnosis.

OCCG was successful in applying for funding from both NHS England’s Diabetes Transformation Fund and the ‘Healthier You: NHS Diabetes Prevention Programme’ (NDPP). The Diabetes Transformation Fund will allow an increase in diabetes staffing to run more and better education courses for those with type 1 and 2 diabetes, and work with GP practices and consultants to improve the way that patients are supported.

The NDPP is a joint commitment from NHS England, Public Health England and Diabetes UK with the aim to delay the onset or prevent altogether Type 2 Diabetes developing. Type 2 Diabetes treatment accounts for just under 9% of the annual NHS budget. The programme will identify those at high risk of developing Type 2 Diabetes and those referred will get tailored, personalised help to reduce their risk of Type 2 Diabetes, including education on healthy eating and lifestyle, help to lose weight and improve physical activity – all of which together are proven to reduce the risk of developing diabetes. It is due to start in the summer of 2017.

During 2016/17 work has continued to ensure we commission a Musculoskeletal (MSK) service, in the community that is sustainable for the future, meets patient need, is efficient and provides a high quality service for patients. This project is currently out to tender with the aim of a new service starting in October 2017. We expect to see a reduction in waits for physiotherapy and podiatry as a result with more streamlined services across the county including the ability for people to self-refer.

Whilst we have seen improvements across planned care we are still experiencing challenges with reaching targets for cancer referral times and for patients starting their treatment within 18 weeks of referral. The standard of 92% of patients starting their treatment within 18 weeks of referral over the past year was not met. Plans are being developed to improve the performance in this area.

The number of people being seen for a first outpatient appointment within two weeks of an urgent referral with breast symptoms (where cancer was not initially suspected) was narrowly missed with 92.2% being seen within two week (target of 93%) as was the target of patients waiting no longer than one month (31 days) from an urgent GP referral to the first definitive treatment (95.6% against a standard of 96%). We were unable to meet the timeframe for the number of people waiting no longer than two months (62 day) from an urgent GP referral to the first definitive treatment (78.1 % against a standard of 85%). However all other main targets were achieved (see page 11).

To help improve cancer waiting times OCCG launched, a Cancer Research UK funded, early diagnosis project for suspected cancer (SCAN) on 15 March 2017 for GPs to refer patients that they suspected as having cancer but do not meet requirements for the 2 week wait pathways, this is only open to the North of the county at the moment but plans are underway to gradually introduce the service to all the localities, with everyone having access by September 2017. We hope that this will help to diagnose cancers and get people starting their treatment earlier.

Improving mental health services

Mental ill-health affects large numbers of the population in all age groups with those experiencing mental illness dying 15 to 20 years earlier than other people. Parity of esteem, the principle by which mental health must be given equal priority to physical health, remains a challenge locally.

In 2015 OCCG commissioned a seven year outcomes based contract for adults with mental illness. The contract, designed with the help of patients and carers, aims to improve mental health outcomes for people aged 18 to 65 bringing together in-patient, community psychiatry and psychology, housing and support, recovery services, employment support and a well-being service. The service provides seven day access, assessment within four hours, seven days or 28 days depending on the level of urgency and personalised user led care planning to help people achieve their personal recovery goals. Ultimately the aim of this service is to enable people with a severe mental illness to live as independently as possible.

The contract incentivises Oxford Health NHS Foundation Trust (OHFT) and its voluntary sector partners (Mental Health Partnership[7]) to deliver the following outcomes:

- Increased life expectancy for people with severe mental illness
- Increased access for patients in crisis, with a new two hour response target
- An individual recovery plan where progress is both patient and clinically assessed
- Increased numbers of people with severe mental illness in work, in education, or in structured volunteering
- Increased carer satisfaction with the support they receive and the person they care for receives
- Increased numbers of people in medium / long term secured accommodation
- Improvements in the physical health of people with severe mental illness, increasing the number of people with a healthy body mass index and reducing the numbers who smoke.

OCCG was recognised for its work improving outcomes for patients when it won a NHS Clinical Commissioners 'Healthcare Transformation Award' in June 2016 for the best entry in the category *'commissioning for outcomes and reducing variation'*. Judges at the awards ceremony were impressed with the OCCG's commitment to engaging with patients and carers in developing the outcomes based contract. Judges also highlighted how OCCG had brought together health and social care funding in an integrated approach to the commissioning and delivery of services in Oxfordshire.

In July 2016, OCCG supported an Oxfordshire Mental Health Partnership event - Celebrating Lives. The event was led, planned and organised by group of people who have experienced mental illness in partnership with staff from the new Oxfordshire Mental Health Partnership. The event aimed to share service user's experiences, to celebrate lives and motivate. Its purpose was also to share information on services and support available in Oxfordshire and develop models of participation led by service users. Activities included workshops on art, music and poetry; a presentation on the value of user groups and display stands from mental health partnership groups. Over

[7] The Mental Health Partnership comprises OHFT, Oxfordshire Mind, Restore, Response, Connection Floating Support and Elmore Community Services.

50 service users attended the event; at the end of the day those who attended felt more hopeful for the future and were pleased to have more information in order for them to develop their own plans to manage their difficulties and to stay well.

During the past year, OCCG and OHFT were successful in securing funds to expand its Improving Access to Psychological Therapies (IAPT) services to support people with long term conditions (LTC) namely those with diabetes, chronic obstructive pulmonary disorder and cardiac conditions. People with LTCs are three times more likely to have anxiety and/or depression than the general population. The new model integrates IAPT services into those services already provided for people with LTCs giving them access to therapies such as self-help guides, group therapy sessions and cognitive behavioural therapy. The project will run through 2017/18; it will be evaluated to understand its impact and future commissioning decisions.

Improving Care for people with learning disabilities

OCCG took over the commissioning of services for people with learning disabilities from Oxfordshire County Council (OCC) in July 2016.

There are more than 11,000 people with learning disabilities in Oxfordshire who currently use services provided by Southern Health NHS Foundation Trust. This contract is due to run until the end of December 2017. OCCG and Southern Health have been working closely to ensure a safe and smooth transition of services to a new provider. People who use services, their families and carers are being kept fully informed as the transition takes place.

The new provider will be OHFT which is respected for its expertise in services for people with learning disabilities, having provided children's and young people's services across the county for some time. Most of the staff in Southern Health's community teams (such as nurses, physios, occupational therapists and psychiatrists) will continue to work with the people who currently use their services, as staff will be transferring to OHFT. As a result, it is hoped most people, their families and carers will not experience any significant changes in their day to day activities as they will be dealing with the same professionals.

Once the transition is complete OCCG will continue working with OHFT to develop plans to transform learning disability services in line with the national 'Transforming Care' programme.

Oxfordshire CCG's new contract with OHFT will play a key role in delivering the Oxfordshire Transforming Care Plan 2016 - 2019, which aims to:

- improve people's physical and mental health
- improve the quality of services
- help people stay safe and out of trouble
- help people be active in their communities
- improve support for families and carers

- improve how children move to adult services
- help children and families get support earlier
- improve people's choices about where they live

The strategy has been shaped by people with learning disabilities, their families, friends, carers and the people who work with them sharing their priorities with OCCG.

As part of continued engagement and conversation with people with learning disabilities, a workshop event in Didcot in October 2016, hosted by OCCG and other stakeholder organisations, invited people with learning disabilities and autism, family carers and the workforce to share their views on future services, OCCG's review into the deaths of people with learning disabilities and the work of the Learning Disability Intensive Support Team.

Children & Families

For the past 10 years the NHS in Oxfordshire has worked with OCC to develop a range of services for children with disabilities. This includes residential care and community based short breaks. With the contracts coming to an end it was a good opportunity for us to review the service provided.

OCC led the review and involved a range of people through workshops and focus groups to understand if there were any gaps in services, what had worked well or not worked well and why. This information helped OCCG and OCC to decide where to locate new services to better support families with a disabled child / children in Oxfordshire.

With the joint budget OCCG and OCC have re-commissioned the following services:

- short breaks and childcare, to include out of school services (holiday play schemes and after school clubs); teenage activities (holiday activities and youth groups); specialist service for children and young people with high functioning autism and Asperger's Syndrome (holiday activities, youth groups and family support)
- Specialist residential respite and short breaks service (overnight breaks)
- The Children's Home for children with disabilities.

OCCG has also reviewed and has changed the way we commission mental health services for young people. OHFT currently provides a range of child and adolescent mental health services (CAMHS) on behalf of OCCG under one large community contract. To encourage better integration and performance, these services are now being commissioned on a separate contract and jointly commissioned with OCC. This allow a greater focus on performance including the introduction of an outcome based incentive payment, similar to the outcome based contract held for adult mental health services.

The new contract aims to improve the quality and volume of CAMHS delivered in Oxfordshire. In particular it will concentrate on reducing waiting times, which have

already reduced significantly this year with an average wait of less than 12 weeks and a new service for autism diagnosis, reducing long waits there.

In the new contract Oxford Health will be teaming up with a selection of voluntary sector organisations to ensure the needs of young people can be met in different and innovative ways. This year OCCG also published the Oxfordshire CAMHS Transformation Plan that gives detail about how we see services changing over the next five years with ambitious plans.

Maternity services

Last year OUHFT provided maternity services not just for local women but also for up to 1000 women from surrounding counties. There were 8500 births across the six units in Oxfordshire which include two separate obstetric units, one alongside midwifery led unit (MLU) and three freestanding MLUs in Chipping Norton, Wantage and Wallingford.

In October 2016 OUHFT temporarily suspended the obstetric led service at the Horton General Hospital in Banbury because of difficulties in recruiting doctors and therefore not being able to provide a safe obstetric service; the unit temporarily became a Midwifery-Led Unit (MLU). The temporary change also affected the Special Care Baby Unit, which has temporarily transferred to the John Radcliffe Hospital in Oxford because this kind of care is only provided alongside obstetric units. The emergency gynaecological service has also transferred to the John Radcliffe Hospital as it had previously been provided by those doctors in the obstetric unit. By March 2017, nearly 100 women had given birth at the Horton MLU and other women from the area chose to give birth in one of the surrounding hospitals, the John Radcliffe, Northampton General and Warwick Hospital. The MLU continues to provide a safe alternative for low risk women.

Work to recruit obstetricians continues but nationally there is a shortage of obstetric consultants and middle grade doctors. It is particularly hard to recruit staff to work at the Horton General Hospital because of the low number of births in the unit. OUHFT has continued to try to recruit more obstetric staff but until now has not been successful. Proposals to make permanent the temporary suspension of the obstetric led service at the Horton General Hospital are part of the Oxfordshire Transformation Programme phase 1 public consultation.

Managing medicines better

In 2016/17 OCCG spent **£XX** million on medicines prescribed by family doctors for the population in Oxfordshire, **XX%** of our overall budget. As in previous years, there were significant cost pressures on prescribing but OCCG's Medicines Optimisation Team continued to work closely with GP practices and other clinicians to promote good quality, cost-effective prescribing across the county. Each practice had a prescribing

meeting with a Prescribing Adviser where priorities were discussed and a plan made for the year. As a result, practices improved care and reduced costs.

Following on from last year, significant work was done to ensure that prescribing of antimicrobials was appropriate leading to a reduction of **XX**. The prescribing of antibiotics in OCCG is considerably lower than national average although our prescribing of high-risk antibiotics is above national average. Work also continued to review the prescribing of SIP feeds (liquid oral nutritional supplements) leading to savings of **£XX** being made during 2016/17.

OCCG continually reviews guidelines to support appropriate prescribing in primary care as well as introduce new guidance. In 2016, OCCG decided that, where appropriate, patients should be encouraged to buy medication over the counter in order to make more NHS resources available for medicines which cannot be purchased by patients directly. A policy statement was produced to this effect. Various resources are used to monitor local prescribing in order to identify where review is needed. The NHS England Medicines Optimisation Dashboard provides data and the NHS RightCare Programme is useful in identifying where the OCCG is different compared with other clinical commissioning groups with similar population health.

During 2016/17 a new on-line prescribing formulary was approved for use by all prescribers in primary care across Oxfordshire. This goes live in April 2017 and should lead to greater adherence to OCCG's recommended choice of medicines. This should improve both the quality and cost effectiveness of prescribing. In addition, the continued use of ScriptSwitch, an IT prescribing decision support tool which provides information such as patient safety, drug switch recommendations and dosage optimisation at the point of prescribing. This has generated savings for OCCG throughout the year by recommending cost effective switches which can be accepted by prescribers. The tool is available to all the practices resulting in a saving of approximately **£XX** in 2016/17.

A Minor Ailment Scheme (MAS) continued to be provided at some pharmacies in the county resulting in a reduction in waiting times and GP workload. In addition, in July 2016, a small pilot was initiated whereby 14 community pharmacies in Oxfordshire are able to provide advice and treatment to appropriate patients with uncomplicated urinary tract infections (UTIs) using a Patient Group Direction (PGD). The aim of the service is to reduce pressure on GP practices and Out of Hours services by redirecting some patients to a pharmacy. The scheme has now been extended until March 2018.

Improving quality

Improving the quality of healthcare provided to people in Oxfordshire is at the heart of our work. To enable OCCG to do this systematically we collect feedback from members of the public about their experiences of healthcare through a range of methods including compliments and complaints; patient experience surveys and provider performance data.

We also provide a feedback mechanism for GPs to share information with us on the services commissioned by OCCG. Datix, OCCG's online quality reporting system, continues to be an effective tool for GPs and is helping to improve the quality of services. It allows us to capture GP feedback across our 72 GP practices so we can identify the causes of commonly occurring incidents and identify trends. We work with providers to prevent them happening again. The information allows us to identify problems early to find solutions and improve care for patients.

Between April 2016 and March 2017, 2004 pieces of feedback were reported via Datix. This information is used with information from serious incidents, patient experience and performance data to identify where services and care could be improved.

OCCG's Quality Team addresses issues identified. 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 that we are applying pressure through the service contract where the change is too slow.

In July 2016, our Quality team was shortlisted for a Health Service Journal Patient Safety Award for Preventing Avoidable Harm. This was as a result of the GP Feedback programme using Datix which has led to many quality improvements in all provider organisations. The results of the programme demonstrated to the panel were well received as we showed we had made significant quality improvements to patient care across Oxfordshire in the following top three areas:

1. Improving the speed of clinical communication which is now meeting the contractual timeframe around 80% of the time
2. The management of test results/endorsement of tests from a clinician within the contractual timeframe has improved across all specialties
3. Inappropriate prescribing requests have reduced

OCCG has received 34 formal complaints during 2016/17. One complaint was referred to the Ombudsman and required no further action from OCCG.

When a serious incident (SI) 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. There were 222 serious incidents reported to us during 2016/17. As an organisation, OCCG has not declared any serious incidents. Information on how these incidents are disclosed and managed is available in OCCG's Governance Statement on page 49.

As a result of a small number of serious incidents, the CCG has worked closely with the OUHFT to improve processes for managing clinical test results. Part of this work was to ensure clinicians use the electronic patient records to endorse the result. In January 2017, OUHFT achieved this in 81.6% of cases which is an improvement of 20% since the start of 2016.

All 72 of our GP practices have now been inspected by the CQC. Four are rated as outstanding, 58 are rated good and 10 are rated as requires improvement. No practices have received an inadequate rating. We are working with the 10 practices that require improvement to ensure they receive a good rating when re-inspected later in the year.

All our hospital and community service providers are rated as “good”, however all have plans to improve compliance with the Care Quality Commission (CQC) standards and OCCG monitor these through our contract meetings.

OCCG has rolled out the national e-referrals system (ERS) to all providers in Oxfordshire. ERS shows waiting times for a number of hospitals and links to the NHS Choices website which gives information on the quality of the services. This system allows patients to choose the hospital / service they prefer and book on line or by phone.

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

In 2015 OCCG commissioned the Patients Association to undertake a mystery shopping project. The project took place between February and September 2016. The project recruited patients of the four sites of OUHFT to provide feedback on their experiences. All those who provided feedback were genuine patients using services. We were particularly interested to find out about administration of appointments and admissions and to see whether staff introduced themselves to patients. 20% of patients had their outpatient appointments changed and over 40% had their inpatient admission date changed. This is also apparent in OUHFT’s own patient feedback. Overall, patients reported very positive experiences of care.

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.

Looking after our most vulnerable

OCCG continues to work with partner organisations (NHS, police and OCC) to ensure we are doing everything we can to protect vulnerable people in the community. Oxfordshire has two safeguarding Boards one for children and one for adults which coordinate this work across statutory, private and voluntary organisations.

Oxfordshire Safeguarding Children Board (OSCB) is the means by which organisations in Oxfordshire come together to agree on how they will cooperate with one another to safeguard and promote the welfare of children. The role of the Oxfordshire Safeguarding Children Board (OSCB) is to scrutinise and monitor this process, and to ensure that local agencies co-operate and work well to achieve this. Part of its role is to commission independent reviews when a child dies or is seriously injured and abuse or neglect is thought to be involved.

Similar to the OSCB, there is an Oxfordshire Safeguarding Adults Board (OSAB), made up of a group of organisations across Oxfordshire who work together to support and protect vulnerable adults in the community.

In November 2016, OCCG submitted its safeguarding self-assessment to the Oxfordshire safeguarding boards. This is an annual assessment that incorporates the standards from the Children Act (2004) section 11 requirements and standards for adult services developed from the 2014 Care Act by the Local Government Association. The standards cover four areas:

1. Leadership, strategy and working together;
2. Commissioning, service delivery and effective practice;
3. Performance and resource management;
4. Outcomes for, and experiences of, people who use statutory services.

We provided evidence of compliance for all the standards within the assessment. Good practice was seen in the regular updates provided to OCCG's Quality Committee and OCCG's Board, the development of a data set and the coordination of health care teams in safeguarding practice.

The assessment included staff knowledge of current safeguarding practices. Questionnaires were returned from 25 staff across the OCCG directorates. Our staff's knowledge was found to be of a good standard, commensurate with their roles, with everyone aware of how to access procedures and advice when required. Seventy six per cent of staff felt they would be confident to ask providers about safeguarding issues. Those identifying a lack of confidence would not normally contact providers directly. Ninety-six percent of staff were clear about how to manage allegations about a staff member and all staff were able to name the safeguarding leads in the organisation.

A peer review of this self-assessment was undertaken in March 2017 by the Oxfordshire safeguarding boards took place in March. The event provided opportunities for shared learning and improved understanding of practice across the safeguarding partnership. Practitioners and managers shared their self-assessments, which were completed and submitted to the safeguarding boards in November 2016. The evidence

presented in the self-assessments was commended by the Independent Chair of the children's board. Health service teams were cited as providing some examples of excellent practice across the partnership.

Following the publication of the Mazars Report, OCCG has undertaken a retrospective review of all deaths of Oxfordshire residents with learning disabilities in the period of the review (1/4/2011 – 31/3/2015). One hundred and six individuals were reviewed. Wherever possible the next of kin was identified, contacted and asked how they would like to be involved. Of the 106, 60 were closed with the decision being made that we had sufficient evidence to conclude that there were no significant deficits in their care and that we had sufficient information to close. For six there were existing investigations. For the remaining 40 we took the decision that we needed further information. This has included the agencies involved in their care undertaking an audit of their care. There was a focus on the areas identified by Mazars as requiring further scrutiny including delays in referral for treatment, health assessments and nutrition. Two multiagency events have been held where multidisciplinary groups were asked to review the cases – this work continues.

Sustainable development

The NHS Carbon Reduction Strategy for England sets an ambition for the NHS to help drive change towards a low carbon society. The strategy shows the scale of reduction in carbon required for the NHS to meet its legal targets set out in the Climate Change Act to reduce 34% of carbon emissions by 2020. OCCG has a Board representative for sustainability and has developed a Sustainability Strategy and Management Plan (SSMP), which sets out how we aim to reduce carbon emissions and embed sustainability within our operations.

OCCG has worked in collaboration with the Centre for Sustainable Healthcare to provide training workshops on sustainable commissioning for staff, and to embed sustainable approaches within our procurement policy. In addition we are working with the Centre for Sustainable Healthcare to implement the 'Inhaler Recycling Scheme' project with local pharmacies. The Inhaler Recycling Scheme has three objectives:

- To improve outcomes and quality of life for patients with asthma or COPD, while reducing emergency admissions
- To reduce medicines waste
- To lessen the environmental impact of inhalers by reducing the amount of propellant gases (hydro fluorocarbons) from metered dose inhalers released into the atmosphere

The NHS Standard Contract requires our providers to minimise adverse impact on the environment and report on sustainability in their annual report. In addition our providers must give due regard to the Public Services (Social Value) Act 2012. In March 2017 we

published our third Sustainable Development Unit - Good Corporate Citizen Report, with an improved score of 51% up from 47% last year.

OCCG acknowledges the responsibility to our patients, local communities and the environment by working hard to minimise our carbon footprint. More details on our work on sustainable development including links to the carbon footprint report and the Good Corporate Citizen score can be found here.

Reducing health inequality

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

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

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

During 2016 we have continued to build on the excellent equalities work already undertaken and have made good progress implementing the actions, gaps and constraints arising from our work for the Equality Delivery System (EDS2) and Workforce Race Equality Standard (WRES).

Our Equality Reference Group (ERG) continues to work with patients, the voluntary sector and other key stakeholders such as Healthwatch Oxfordshire to address any equality and diversity issues in relation to patients and services. During 2016 a Public Co-Chair was appointed to the ERG. The remit of this role is to encourage and facilitate member participation and establish constructive relationships. The Co-Chair works in partnership with OCCG to support the meetings by setting the agenda and forward work plan as well as assisting with recruitment of new members to the group and ensuring wide representation of the nine protected groups.

Members of the ERG have continuously monitored progress against our action plan for the Equality Delivery System (EDS2) and two patient-focused goals:

- Goal 1: Better Health Outcomes and

- Goal 2: Improved Patient Access and Experience

This year, in response to feedback from the previous EDS2 exercise in 2015, more evidence was presented to the ERG in the form of patient stories from outreach work and with seldom heard groups. This was used to support the grading process and members of the ERG verified our EDS2 grades for the two patient-focused goals and related outcomes by examining the new evidence presented to them. In addition to the patient stories additional evidence included:

- End of Life Care Digital Pro-active Care Plan
- Mazars Report into Learning Disability Deaths and work undertaken by OCCG to address findings
- Bicester and Barton Healthy New Town Programmes

As a result of the additional evidence and work achieved, OCCG is pleased that our EDS2 grades for 2016 have improved.

The implementation of the WRES is a requirement on both NHS commissioners and provider organisations. The WRES report sets out the OCCG performance information against nine mandatory WRES metrics. The metrics cover the workforce profile and board composition, by ethnicity. In 2015 OCCG did not have the data available in the WRES format. During 2016 we have worked towards collating data that has now made it possible to cover each metric.

OCCG is a relatively small employer and 24 out of 124 members of staff in the 2016 staff survey did not disclose their ethnic origin. Therefore the figures may not be completely representative of the workforce. We recognise that staff have the right to not disclose these details, but OCCG will continue to strive to increase self-reporting of all protected characteristics. The full OCCG WRES report (July 2016) can be seen here

As part of the suite of statutory and mandatory training all OCCG employees are required to undertake Equality, Diversity and Human Rights training every three years. It is aimed at improving the ability of all OCCG staff to understand some of the potential issues and barriers faced by colleagues and patients from diverse backgrounds and contribute to ensuring that access and services are appropriate to individual's needs. Seventy per cent of staff have now completed this training.

The EDS2 goals for the WRES are:

- Goal 3: Representative and Supported Workforce and
- Goal 4: Inclusive Leadership

The Staff Partnership Forum evaluated the scores against each of the goals and related outcomes for the workforce. As with the patient-focused goals and outcomes, additional evidence was sought to support this year's evaluation of OCCG's EDS2 grades for the workforce and included:

- Results of the 2016 Staff Survey and actions that were taken

- Equality Analysis training of Board members and key staff
- Introduction of values and values based appraisals

Looking forward to the remainder of 2017 we will be working with the Equality Reference Group and Staff Partnership Forum to develop an action plan to continue to improve our EDS2 ratings. We hope that through our regular consultations/engagement, refugee and asylum work and community outreach work that the Equality Reference Group, patients and people with protected characteristics feel empowered and are able to support us towards improvement of services.

During 2016 OCCG supported the formation of a Health Inequalities Commission; its members included an independent chair and members from statutory, voluntary and academic organisations. OCCG's Clinical Chair was a member. The role of the Commission was to gather evidence and make recommendations for reducing health inequalities.

During 2016 the Commission held four public evidence hearing sessions to gather information from statutory, voluntary and community members on the perceived issues and needs to address health inequalities in Oxfordshire. The sessions covered all ages across the life-course - from beginning well, to living well, through to ageing well. This involved considering aspects of urban and rural living, the experiences of ethnic minority groups and of those populations living in situations of particular disadvantage such as homelessness and poor housing.

The final session also heard evidence on a range of themes such as barriers to accessing services and housing. The feedback from the sessions, together with national data, has now been published. The full report and recommended actions were endorsed by the Oxfordshire's Health and Well Being Board in November 2016 and can be seen here: http://www.oxfordshireccg.nhs.uk/about-us/work-programmes/health-inequalitiescommission/health-inequalities-findings/

During 2017 a cross-organisational implementation group was established to work collectively with the organisations identified as being responsible for the recommendations and to ensure they are prioritised and taken forward. These organisations include OCCG, OUHFT, OHFT and OCC.

Health and wellbeing strategy

Oxfordshire Health and Wellbeing Board is a partnership between local government, the NHS and the people of Oxfordshire. It includes local GPs, councillors, Healthwatch Oxfordshire, and senior local government officers.

The board has been set up to ensure that we work together to improve everyone's health and wellbeing, especially those who have health problems or are in difficult circumstances.

The board provides strategic leadership for health and wellbeing across the county. Dr Joe McManners, the CCG Clinical Chair is the Vice Chairman of the Health and Wellbeing Board which is chaired by the Leader of the council.

Three Partnership Boards and a Public Involvement Network (PIN) report into the HWBB. Each of these groups has a distinct purpose and all have members of the public serving as lay representatives. The responsibilities are outlined below:

- **Adult Health and Social Care Board**: To improve outcomes and to support adults to live independently with dignity by accessing the support and services they need while achieving better value for money.
- **Children and Young People's Board**: To keep all children and young people safe; raise achievement for all children and young people and improve the life chances for our most disadvantaged and vulnerable groups.
- **Health Improvement Board**: To add life to years and years to life, focusing on the factors underpinning wellbeing, whilst levelling the differences in people's health across the county.
- **Public Involvement Network**: To ensure that the genuine opinions and experiences of people in Oxfordshire underpin the work of the Health and Wellbeing Board.

The Health and Wellbeing Board is ultimately responsible for making decisions jointly about health and wellbeing. Its members are committed to working with its three Partnership Boards and its Public Involvement Network to make those decisions. They are also accountable to their constituent organisations; the Oxfordshire Clinical Commissioning Group, County, District and City Councils and HealthWatch Oxfordshire. In turn, the Partnership Boards are committed to working with a wide range of health care providers, voluntary agencies and advocacy groups.

Oxfordshire's Joint Health and Wellbeing Strategy was revised and updated in 2016. This revised strategy (2016-2019) was developed in partnership with members of the Health and wellbeing Board, the Partnership Boards and the Public Involvement Network. We have continued the approach of setting outcomes for all our Health and Wellbeing priorities and of receiving updates on performance at each meeting of the Health and Wellbeing Board. This revised strategy sets out our ambition for the year ahead which helps us to drive improvement on the issues that need a partnership approach.

Particular successes in the last year included:

- Many children have a healthy start to life, demonstrated by higher than average rates for breastfeeding and good coverage of immunisations – though there is still room for more improvement.
- More young carers have been identified and are receiving support.
- Progress is being made on the integration of health and social care services.

- Over 30,000 people had information and advice about areas of support through the Community Information Networks
- Uptake of invitations to attend NHS Health Checks remained steady during the year
- The percentage of children who were overweight or obese in Year 6 last year was lower than in the previous year, helping us towards the target of stalling the general rise in obesity rates and going against the national trend.
- The Affordable Warmth Network reported full take up of grant aided schemes and also a growth in referrals from health services.

The new developments for this year informed the work of the Health and Wellbeing Board. This included the work to produce a Sustainability and Transformation Plan across the health and care system.

The Health Inequalities Commission was established at the request of the Health and Wellbeing Board and in November 2016 published its report on addressing the health inequalities in Oxfordshire. This report has been published and discussed widely at the Health and Wellbeing Board, the CCG Board and the Health Overview and Scrutiny Committee. Its findings and recommendations are being used in developing plans of all partner organisations.

The Health and wellbeing Strategy is available here and the Health Inequalities Commission report is available here.

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 Local Health Resilience Partnership
- 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 exercises and testing programmes as part of the NHS England South (South Central) assurance process

- Provides commissioned providers with a route of escalation on a 24/7 basis if they fail to maintain their professional levels
- Respond to reasonable requests to assist and co-operate
- Support NHS England South (South Central) should any emergency require any 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 for leadership for EPRR. In OCCG it is the Director of Governance who holds this executive responsibility. A 24/7 director on call rota is in place to deal with any issues escalated to us by our providers and a 24/7 communications on call rota exists for media and communications issues.

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

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

- Exercise Cascade – testing communications cascade within OCCG and the ability of staff to access email and computer drives while off site
- Tactical Command Training – demonstrating the role of tactical command at a Tactical Co-ordination Group
- Director on Call Training sessions focusing on escalation using the joint decision making model (JESIP) and METHANE[8] reporting method.

The Emergency Planning Officer and Assistant Governance Manager both undertook and passed the Certificate of Business Continuity Institute (CBCI) examination. The CBCI is assurance that professionals have the full knowledge and understanding of the theory of global good practice in business continuity.

- [8] METHANE is a reporting protocol used by emergency services to report situations which they may be faced with, especially as it relates to major incidents, where it may be used as part of their emergency action principles. (**Major** incident declared; **Exact** location: The precise location of the incident; **Type** The nature of the incident, including how many vehicles, buildings and so on are involved; **Hazards**: Both present and potential; **Access:** Best route for emergency services to access the site, or obstructions and bottlenecks to avoid; **Numbers**: Numbers of casualties, dead and uninjured on scene; **Emergency services:** Which services are already on scene, and which others are required).

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

Patient and public involvement

OCCG's agreed values underpin the importance communicating and engaging with our local population is key to achieving our vision. In accordance with Section 14Z2 of the Health and Social Care Act (as amended), OCCG has met it's legal duty to ensure that individuals to whom services are being or may be provided are involved in the planning, development and operation of commissioning arrangements. To this end we have a communications and engagement strategy, which sets out our approach to communicating and engaging with people in Oxfordshire. It is based on the principle of open and continuous communication with patients, the public, OCCG members, staff and key stakeholders. It also acknowledges OCCG's statutory responsibilities and the NHS commitment to involve patients in how health services are planned and managed.

OCCG is committed to putting the patient first and applying the principle of 'No decision about me without me' in its commissioning approach. This means we will try to improve communication and increase patient participation and public engagement in as many aspects of OCCG's work as possible. At OCCG we want our public, patients, carers, partners and other stakeholders to be involved in our work.

For each individual project or stream of work OCCG evaluates the requirement for engagement and consultation and maps the type and methodologies that it might use. This may include public meetings, workshops, surveys and focus groups.

As part of the continuous development of primary care services, a patient representative sits on the Oxfordshire Primary Care Commissioning Committee and is drawn from the Primary Care Patient Advisory Group, which has representation from each locality, Carers Oxfordshire, the University of Oxford and Healthwatch Oxfordshire.

A major piece of work undertaken in the past year was the public involvement in the Oxfordshire Health Transformation Programme. From June to December 2016 patients and the public were invited to get involved in the development of proposals to transform the way health and care is delivered in the county. This period of engagement helped inform our thinking, develop plans and inform our ideas for the way services might be best provided in the future.

During this period we held six public roadshows across Oxfordshire, with 359 people attending in total. In parallel we also ran a survey which received 209 responses. In addition to the roadshows we also met with a variety of key stakeholders including the Community Partnership Network in Banbury, local MPs and councillors.

Further engagement continued into the Autumn of 2016 and included:

- Four further information displays in market towns across Oxfordshire
- Three focus groups with mothers, that had used services at John Radcliffe, Horton General Hospital and Chipping Norton Midwife Led Unit
- Three focus groups with students at Abingdon and Witney College, specifically looking at primary care services
- An additional survey that received a further 48 responses
- Additional stakeholder meetings that had over 250 attendances
- 70 Letters and/or correspondence including emails
- Met with 145 individuals from 'seldom heard groups'
- Awareness raising through local media and social media

As part of the on-going commitment to patient and public involvement, OCCG also has a network of patient and public locality forums in each of its six localities, which are drawn from patient participation groups (PPGs) and local people from within their locality. The chairs of the locality forums meet regularly with OCCG to ensure two way conversations about issues concerning member of their forums and the local community. Members of Locality Forums also meet regularly meet with GP members in their Locality. The 'Big Health and Care Conversation' was a key point of discussion for each of the locality forums.

OCCG makes every endeavour to hear the voices of all key stakeholders when engaging on particular topics. For some groups this means that we go to them at their locations, rather than expecting people to attend our events.

We continually try to develop our reach to seek feedback and engage people in Oxfordshire from 'seldom heard groups'. We do this through researching what methods work well for individuals, groups and communities and working through partner organisations with existing relationships as appropriate.

As noted on page 35, we have an Equality Reference Group, which consists of patient and public members from the nine protected characteristic groups. This group supports OCCG with its equality agenda and is its stakeholder advisory group for the EDS2 (Equality Delivery System) grading. This group is also consulted on equality analyses for service re-designs. There is lay representation and patient representatives on many OCCG committees and project groups.

Our approach to engaging with people from the protected characteristic groups is to also work with community groups which represent some of the nine protected characteristics and these meetings are sometimes led by community or organisation facilitators.

In phase 1 of the Oxfordshire Health Transformation Programme consultation, which started in January 2017, we coordinated outreach to community groups predominantly based in Banbury through our Access and Equalities team. The team developed a schedule of appointments with various community groups, where they explained what the consultation was about, shared the consultation documents, answered questions and listened to views from members. The team also encouraged people to complete the

survey either online or using the paper version. We also translated the consultation documents and the survey into Urdu and Polish. An Easy Read format is used aimed at Learning Disability groups but could be used for any group where literacy is an issue). Translations into other languages were available on request.

We also commissioned an external organisation to support the consultation work. We achieved a good level of response from most sections of the community through the engagement opportunities offered during the consultation but we sought to ensure those groups that are less likely to engage have had an opportunity to share their views.

[Insert signature]

David Smith
Accountable Officer
XX May 2017

ACCOUNTABILITY REPORT

Corporate Governance Report

Members' Report

OCCG is a clinically led membership organisation made up of 72 general practices, grouped into six localities. Each locality's population has different needs and working this way allows individual GP practices in the localities to reflect local health needs in the services that we buy. The GP practices within each locality meet on a regular basis to discuss progress on their priorities for healthcare in their area of the county. Each locality has a GP who is a Locality Clinical Director and is a member of the OCCG Board. Each locality has a patient and public forum that works closely with the locality group of GPs to ensure patient views are included in discussions and decisions about healthcare in their area and throughout Oxfordshire.

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

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

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

The Membership Body is represented on the Board through the six Locality Clinical Directors who are appointed in line with their locality constitutions. Through agreement of the constitution, the Membership Body has agreed that the Board will be responsible for:

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

As of 31 March 2017, our localities and practices included:

North East Oxfordshire

There are 7 GP practices in the locality with a combined population of just over 82,000. The Locality Clinical Director is Dr Stephen Attwood, who is supported by Dr Will O'Gorman. The seven practices are:

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

North Oxfordshire

There are 12 GP practices in the locality with a population of around 110,500. The Locality Clinical Director is Dr Paul Park, who is supported by Dr Shelley Hayles as deputy. The 12 practices are:

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

Oxford City

In 2016/17 there were 22* GP practices in the locality with a population of over 215,000. The Locality Clinical Director is Dr David Chapman supported by Dr Merlin Dunlop, Dr Karen Kearley and Dr Andy Valentine. The 22 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. Cowley Road Medical Practice
9. Donnington Medical Partnership
10. Hollow Way Medical Centre
11. Jericho Health Centre (Leaver)
12. Kennington Health Centre
13. King Edward Street
14. Luther Street Medical Centre

15. Manor Surgery
16. Observatory Medical Practice
17. South Oxford Health Centre
18. St Bartholomews MC Cowley
19. St Clements Surgery
20. Summertown Medical Group
21. Temple Cowley Health Centre
22. The Leys Health Centre

South East Oxfordshire

There are 10 GP practices in the locality with a population of around 90,500. The Locality Clinical Director is Dr Andrew Burnett, who is supported by Dr Amar Latif. The 10 practices are:

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

South West Oxfordshire

There are 12 GP practices in the locality with a population of around 145,000. The Locality Clinical Director is Dr Julie Anderson. The 12 practices are:

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

West Oxfordshire

In 2016/17 there were 9* GP practices in the locality with a population of nearly 81,000 patients. Dr Miles Carter is the Locality Clinical Director, who is supported by Dr Kiren Collison. These nine practices included:

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

*To note: As of 1 April 2017 there are 70 GP practices within OCCG. Kennington Health Centre merged with Botley Medical Centre in the City locality and Deer Park Surgery in Witney (West Locality) closed.

Members of the Board

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

- Dr Joe McManners, Clinical Chair
- David Smith, Chief Executive (Accountable Officer)

The Board of OCCG comprises GP representatives, lay members, executive directors and representatives from Public Health, Adult Social Care and an external Medical Specialist. Individual profiles are available on our website here. The composition of the Board as of 31 March 2017 includes:

- Dr Julie Anderson, South West Locality Clinical Director
- Dr Stephen Attwood, North East Locality Clinical Director
- Dr Andrew Burnett, South East Locality Clinical Director
- Dr Miles Carter, West Locality Clinical Director
- Dr David Chapman, Oxford City Clinical Director
- Mike Delaney, Lay Member
- Roger Dickinson, Lay Member Lead for Governance, Vice Chair and Audit Committee Chair
- Diane Hedges, Chief Operating Officer
- Gareth Kenworthy, Director of Finance
- Stuart MacFarlane, Business Manager at Bury Knowle Health Centre, Headington, representing the views of practice managers across Oxfordshire
- Dr Joe McManners, Clinical Chair
- Dr Jonathan McWilliam, Director of Public Health, Oxfordshire County Council
- Catherine Mountford, Director of Governance
- Dr Paul Park, North Oxfordshire Locality Clinical Director and Deputy Clinical Chair
- Dr Guy Rooney, Medical Specialist Advisor (from June 2016)

- David Smith, Chief Executive
- Duncan Smith, Lay Member for Finance and Finance Committee Chair
- Kate Terroni, Director of Adult Social Services (from September 2016)
- Prof Louise Wallace, Lay Member for Public Participation and Involvement (PPI) and Quality Committee Chair
- Sula Wiltshire, Director of Quality and OCCG Lead Nurse

Other members of the Board during 2016/17 included:

- John Jackson, Director of Adult Social Services, Oxfordshire County Council [until August 2016].

Statement of Disclosure to Auditors

Each individual who is a member of the Board at 31 March 2017 confirms:

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

Please see the Annual Governance Statement on page 50 for information about the committees and sub-committees of the board including membership and attendance.

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

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

Modern Slavery Act

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

Statement of Accountable Officer's Responsibilities

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

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

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

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

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

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

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

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

I also confirm that:

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

Governance Statement

Introduction and context

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

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

As at 1 April 2017, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

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

Through agreement of the Constitution the Practice Members have agreed that the Board will be responsible for:

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

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

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

The 2016/2017 Board agenda has focused on the organisational objectives, national priorities and the local health economy's priorities in the Operational Plan. The Board has also held workshops on strategic and corporate objectives.

Standing agenda items include the Chief Executives Report, Locality Clinical Director Reports, Integrated Performance Report, Finance Report, Corporate Governance Report ,Strategic Risk Register and Board Committee Reports. In addition to the standing agenda items the Board agenda in 2016/2017 has included reporting on:

- Primary Care Strategy
- System Performance – Delayed Transfers of Care
- Oxfordshire Transformation Programme
- Strategy and Transformation Plan
- Health Inequalities Commission Report
- Financial Recovery Plan
- Transforming Care for People with Learning Disabilities
- Emergency Preparedness, Resilience and Response Annual Report and Improvement Plan
- Safeguarding Report
- 2017/2018 Financial Plan, Contracting and Savings

Governing Body Committees

Audit Committee

The Audit Committee provides an independent and objective view of the proper stewardship of OCCG's resources and assets by overseeing internal and external audit services, reviewing internal control systems and processes, monitoring compliance with Standing Orders and Prime Financial Policies, reviewing schedules of losses and compensations, reviewing the information prepared to support the controls of assurance statements, overseeing risk management arrangements and making recommendations to the Board. The role of the Committee includes integrated governance, statutory reporting and assurance in respect of the principal risks and it will monitor and review the systems and frameworks that are in place to manage organisational risk.

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

The Audit Committee met six times during 2016/17 and fulfilled its remit and responsibilities as detailed in the annual work plan. The Committee received regular updates on risk, external audit, internal audit, and security management, general audit matters and financial matters to ensure that risks were appropriately prioritised and adequately controlled and mitigated.

The following internal audits have been received:

- OCCG Constitution
- Financial Reporting and Budgetary Control
- NICE Guidance
- Key Financial Assurance
- IG Toolkit
- Conflict of Interests
- Board Assurance Framework
- Procedures of Limited Clinical Value
- Delayed Transfers of Care (DTOC)
- Off Payroll Contractors

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

The Committee has undertaken a self-assessment of its effectiveness using a self-assessment checklist. Actions arising from this self-assessment will be included in the work plan for 2017/2018.

Finance Committee

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

The Committee comprises at least six Board members: three Lay Board members (including at least one qualified accountant), one Locality Clinical Director, the Director of Finance and the Chief Operating Officer. The Lay Member (Finance) undertakes the role of Chair. Other members of OCCG management and external advisers may be invited to attend where appropriate. A table of attendance is included in Appendix A.

The Finance Committee met seven times during 2016/2017. In addition to standing agenda items reporting on progress on business cases and financial risk, the Committee received reports and updates including:

- Waiting List Management
- Value Based Decision making Framework
- Prime Ministers Challenge Fund Scheme Update
- Transformation Programme Resourcing
- Section 75 Pooled Budgets
- 2016 / 2017 Contract(s) Performance
- Preparation for 2017 / 2018 Contracting round
- Procurement

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

The Committee has undertaken a review of its performance and included the outcome in an annual report. Items have been escalated to the Board where necessary.

Quality Committee

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

The Quality Committee is Chaired by the lay member with responsibility for patient and public involvement who is a voting member along with another lay member from the

Board, the Director of Quality, two locality clinical representatives, Specialist Medical Adviser, Chief Operating Officer and the Director of Governance. Non-voting ex-officio attendees of the committee comprise Clinical Director Quality for acute and community services and primary care, Deputy Director of Quality, Deputy Director Joint Commissioning Oxfordshire County Council (OCC), Deputy Director Public health (OCC) and a patient representative. A table of attendance is included in Appendix A.

The Quality Committee met six times during 2016/2017 and in addition to standing agenda items on quality and performance reports, risk register, clinical effectiveness inspections and reviews the committee has received reports and updates on:

- Learning Disability Mazars Report
- NICE Annual Report
- IFR Annual Report
- Safeguarding Report
- Annual Prescribing Report
- Serious Incident Report
- Infection Control and Nursing Standards Annual Report

Remuneration Committee

The Remuneration Committee met once during 2016/2017 and discussed Directors pay and planning for the future.

Oxfordshire Primary Care Commissioning Committee (OPCCC)

The role of the Committee is to carry out the functions relating to the commissioning of primary medical services in Oxfordshire, including agreeing primary care aspects of the overall CCG commissioning strategy, providing assurance to the Board and NHS England on quality, performance and finance of all services commissioned from primary care which incorporate the delegated funding and funding from the core CCG allocation, design of local incentive schemes, newly designed enhanced services, approving practice mergers and agreeing and monitoring a financial plan and budget, risk assessment, performance framework and annual workplan.

As well as standing agenda items on finance, quality, Head of Primary Care update and risk register the committee has received papers on the following:

- Investment in Primary Care Sustainability and Transformation
- Improving Quality and Safety in Primary Care
- Primary Care Framework
- GP Access Fund
- Patient and Participation Groups
- Quality and Performance Dashboard
- Primary Care Planning for 2017 / 2018

The Committee met five times during 2016/2017 and is chaired by the Lay Member (Finance). Other members include, Lay Vice Chair, Chief Executive, Chief Operating Officer, Director of Governance, Medical Specialist Advisor and two GP (Clinical Chair or Deputy Chair and one other), Healthwatch, Patient Representative and NHS England Representative.

Buckinghamshire, Oxfordshire and Berkshire (BOB) Commissioning Executive
This committee has been formed to commission executive work across the seven CCGs within Buckinghamshire, Oxfordshire and Berkshire West. The purpose of the group is to ensure the way we commission aligns with the STP programmes and ensure the BOB work programmes are embedded in the contracts commissioned by the CCGs.

Terms of Reference for the Committee have been developed which were approved at the September OCCG Board meeting. Memberships includes the three Accountable Officers and three Chairs, Director of Strategy from Aylesbury Vale and Chiltern CCG, Chief Operating Officer from OCCG and Director of Finance from Buckinghamshire CCG. The Committee met once during 2016/2017 and will meet monthly from April 2017. Notes of the meeting will be shared with each CCG Board.

UK Corporate Governance Code
We are not required to comply with the UK Corporate Governance Code. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider relevant to the clinical commissioning group and best practice. This Corporate Governance Report is intended to demonstrate the clinical commissioning group compliance with the principles set out in the Code.

For the financial year ended 31 March 2017 and up to the signing of the statement, we complied with the provisions as set out in the Code and applied the principles of the Code.

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

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

Risk Management arrangements and effectiveness

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 Board Assurance Framework. The Board Assurance Framework 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.

Please see page 9 for detailed information on OCCG's strategic risks and mitigation.

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 Board, in consultation with Executive Directors. This framework is reviewed continuously throughout the year.

A table providing a summary of operational risks as considered by OCCG Board in March 2017 is available here

Other sources of assurance

Internal Control Framework

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

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

The Governance Team co-ordinates production of risk registers, offers advice and training (where required) and works with OCCG Directors via the bi-monthly Directors Risk Review meeting. This meeting is chaired by the Director of Governance and attended by all Directors. The meeting looks at identifying new risk areas and managing them effectively. It reviews the quality of recording its current risks including an up to date description of current risk mitigation, completeness of action plans and the rationale behind the movement of risk ratings. The Governance Team also maintains the OCCG risk cycle and ensures that timely reminders are sent to risk managers for each risk cycle (as per the Board and sub-committee meetings).

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

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

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

- The OCCG Conflict of Interest Policy has been established by the CCG for managing conflicts of interests, gifts and hospitality
- OCCG has submitted quarter one and quarter two returns to demonstrate compliance with NHS England requirements of the revised statutory guidance on managing conflicts of interests for CCGs
- An omission of recording a declaration of interest was noted at the OPCCC meeting of a member in attendance
- Locality registers available on the CCG website may not be up to date

Those actions identified will be completed by the end of June 2017.

Data Quality

Acute Sector

Data Quality in the acute sector is much improved as is awareness of the impact when it is not. Commissioning Support Unit colleagues are working with providers on an on-going basis and are implementing reporting strategies to mitigate the impact on reporting. This includes the development of a national and local data set (SUS-SLAM) reconciliation report across providers.

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

Joint working between provider performance management and analytics has increased. As a result, some of the processes so far applied only to the main acute contracts are starting to be applied to Independent Sector Providers as well.

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

Non Acute

Very significant progress has been made in 2016/2017 for both community contract and mental health contracts in Oxfordshire.

The Community contract has been restructured and service specifications refined and clarified. As a result, it has become much easier to understand what data might be needed to underpin each service. The provider has met fortnightly with OCCG and CSU staff to identify a suitable dataset for each service and clarify reconciliation and data enhancement rules. As a result, we are for the first time able to report on community hospital activity at a more granular level, the reason for the admission is now known i.e. stroke rehabilitation, as well as being able to measure the impact of DTOC on community hospital length of stay.

We have also jointly developed new datasets to underpin the Emergency Multi-disciplinary Unit (EMU) service, the hospital at home service, and children continuing health care service. We continue to work with the provider to close any other data gaps

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

In mental health, an alternative to the highly problematic mental health minimum data set (MHMDS) has been successfully sourced from the provider and has informed the assessment of delivery against agreed outcome measures.

Overall

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

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

Information Governance

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

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured 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.

Every year OCCG need to complete an Information Governance assessment (IG toolkit) and submit to the Department of Health. Data flow mapping and asset register are part of this submission. Data flow mapping is the process of capturing all inbound and outbound data that is valuable to an organisation; while information asset register is a log / register of all the information assets that the organisations hold. Both of these inform the Business Continuity Plans for the organisation and are therefore crucial for the organisations functioning.

OCCG submitted the Information Governance Toolkit with a score of 79% achieving at least level two against all 28 requirements.

Business Critical Models

OCCG does not own or has not developed any business critical models that have supported its planning in 2016 / 2017. 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 OCCG.

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

To mitigate this action plans have been agreed with providers for cancer 62 day waits, referral to treatment incompletes and 52 week waits. Additional capacity is being sourced through independent sector for high referral areas. A Remedial Action Plan for ambulance response times in in place and a Delayed Transfers of Care Action Group has introduced new measures to mitigate the position.

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

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 CCG Board. These opportunities are then developed into business cases for implementation. The project management arrangements, PMO and standard operating framework of the delivery and management of change has seen improvements. Business cases for savings and QIPP are reviewed and approved by OCCG Board having been through scrutiny in sub-committees. Delivery is monitored in the same way.

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 sub-committee.

As part of the 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.

Counter fraud arrangements
TIAA were contracted to provide counter fraud provision for OCCG. The nominated Lead Local Counter Fraud Specialist (LCFS) and all other LCFS who have been engaged in counter fraud activity are accredited. An annual report is produced and presented to the Audit Committee detailing the annual Self Review Tool (SRT). This tool details progress against each of the standards set by NHS Protect and provides a standard for each rating and an overall rating. SRT for 2016/2017 is due for submission by 1 April 2017 with annual report going to Audit Committee on 20 April 2017.

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

Head of Internal Audit Opinion (HoIA)

Introduction

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 AGS.

As at 28 February 2017 (Month 11), NHS Oxfordshire Clinical Commissioning Group (OCCG) reported a year to date surplus of £11.8m and a forecast outturn surplus of £12.92m.

My opinion is set out as follows:

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

Overall Interim Opinion

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.

Basis of opinion

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.

   Additional areas of work that may support the opinion will be determined locally but are not required for Department of Health purposes e.g. any reliance that is being placed upon Third Party Assurances.

Assurance Assessments 2016/17

System	Substantial Assurance	Reasonable Assurance	Limited Assurance	No Assurance
NHS Constitution		✓		
Delayed Transfers of Care		✓		
Quality – NICE Guidance		✓		
Financial Reporting and Budgetary Control		✓		
Key Financial Assurance		✓		
Procedures of Limited Clinical Value		✓		
Conflicts of Interest		✓		
Board Assurance		✓		
Information Governance Toolkit v14	✓			
Quality - Primary Care		✓		
Cyber Security		✓		

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

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

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

Conclusion
No significant control issues have been identified.

Signature

David Smith
Accountable Officer
XX May 2017

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

Each clinical commissioning group has a Remuneration Committee; the role of the committee is to advise on appropriate remuneration levels and terms of service for the Executive Team and Clinical Leads. The committee also sets the framework within which the terms and conditions of senior managers and clinicians are developed and agreed and receives reports of the performance of the accountable officer and individual directors. Membership of the Remuneration Committee at OCCG is made up of the following lay members:

- Mike Delaney, Lay Member
- Roger Dickinson, Lay Member Lead for Governance, Vice Chair and Committee Chair
- Guy Rooney, Medical Specialist Advisor
- Dr Joe McManners, Clinical Chair
- Duncan Smith, Lay Member for Finance
- Louise Wallace, Lay Member for Public Participation and Involvement (PPI)

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.

Policy on the remuneration policy

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

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

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

Remuneration of very senior managers

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

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

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

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

Senior Manager Remuneration (including salary and pension entitlements) 2015/16

Name	Title	Oxfordshire CCG Salary & Fees (Bands of £5000) £000	Taxable benefi (rounded to nearest £100) £00	Annual Performance Related Bonuses £000	Long Term Performanc Related Bonuses £000	All Pension Related Benefits (Bands of £2500 £000	TOTAL Oxfordshire CCG (Bands of £5000) £000
Julie Anderson	Locality Clinical Director	60-65	0	0	0	0-2.5	60-65
Stephen Attwood	Locality Clinical Director	60-65	0	0	0	0-2.5	60-65
Andew Burnett	Locality Clinical Director	45-50	0	0	0	0-2.5	45-50
Fran Butler	Practice Manager Representative	0-5	0	0	0	0-2.5	0-5
Miles Carter	Locality Clinical Director	60-65	0	0	0	22.5-25	85-90
David Chapman	Locality Clinical Director	45-50	0	0	0	37.5-40	85-90
Diane Hedges	Director of Delivery and Localities	110-115	0	0	0	20-22.5	135-140
John Jackson	Director of Strategy and Transformation / Director for Social and Community Services (OCC) 50% Oxfordshire County Council	85-90	0	0	0	0-2.5	85-90
Gareth Kenworthy	Director of Finance	105-110	0	0	0	17.5-20	125-130
Graz Luzzi	Medical Specialist Advisor	10-15	0	0	0	0-2.5	10-15
Stuart MacFarlane	Practice Manager Representative	0-5	0	0	0	0-2.5	0-5
Joe McManners	Clinical Chair	75-80	0	0	0	20-22.5	95-100
Catherine Mountford	Director of Governance	100-105	0	0	0	2.5-5	100-105
Paul Park	Locality Clinical Director	75-80	0	0	0	22.5-25	100-105
David Smith	Chief Executive	160-165	0	0	0	0-2.5	160-165
Ursula Wiltshire	Director of Quality and Innovation	100-105	0	0	0	5-7.5	105-110
Mike Delaney	Independent Lay Member	10-15	0	0	0	0-2.5	10-15
Roger Dickinson	Independent Lay Member, Lead for Governance and Vice Chair	15-20	0	0	0	0-2.5	15-20
Duncan Smith	Independent Lay Member, Lead for Finance	10-15	0	0	0	0-2.5	10-15
Louise Wallace	Independent Lay Member, Lead for Patient Participation and Involvement	10-15	0	0	0	0-2.5	10-15

Note: John Jackson - 50% salary recharge from Oxfordshire County Council - this figure includes VAT which is non-recoverable to OCCG

Pension Benefits as at 31 March 2017

Name	Title	Notes	Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at pension age at 31 March 2017 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1st April 2016 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2017 £'000	Employer's contribution to stakeholder pension £'000
Miles Carter	Locality Clinical Director		0-2.5	0-2.5	10-15	25-30	123	26	149	0
David Chapman	Locality Clinical Director		2.5-5	5-7.5	35-40	85-90	598	109	707	0
Diane Hedges	Chief Operating Officer and Deputy Chief Executi	(*)	0-2.5	0-2.5	20-25	50-55	422	39	461	0
Gareth Kenworthy	Director of Finance		0-2.5	0-2.5	25-30	70-75	359	51	410	0
Joe McManners	Clinical Chair		0-2.5	0-2.5	10-15	30-35	160	18	178	0
Catherine Mountford	Director of Governance		0-2.5	2.5-5	35-40	105-110	670	52	722	0
Paul Park	Locality Clinical Director		0-2.5	0-2.5	15-20	45-50	221	41	262	0
David Smith	Chief Executive	(**)	0-2.5	0-2.5	0	0	1,766	0	0	0
Ursula Wiltshire	Director of Quality and Innovation		0-2.5	2.5-5	35-40	105-110	0	0	0	0

Note: Lay members do not receive pensionable remuneration.

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

(**) David Smith left Pension Scheme Sept 2015

Cash Equivalent Transfer Value

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of

their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

Pension Benefits as at 31 March 2016

Name	Title	Notes	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2016 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 1st April 2015	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2016	Employer's contribution to stakeholder pension
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Miles Carter	Locality Clinical Director		0-2.5	0-2.5	10-15	25-30	107	6	115	0
David Chapman	Locality Clinical Director		0-2.5	5-7.5	30-35	90-95	631	44	682	0
Diane Hedges	Director of Delivery and Localities		0-2.5	0-2.5	20-25	50-55	379	39	422	0
Gareth Kenworthy	Director of Finance		0-2.5	0-2.5	25-30	70-75	341	15	359	0
Joe McManners	Clinical Chair		0-2.5	0-2.5	10-15	30-35	142	15	159	0
Catherine Mountford	Director of Governance		0-2.5	0-2.5	30-35	100-105	458	28	491	0
Paul Park	Locality Clinical Director		0-2.5	0-2.5	15-20	45-50	200	19	221	0
David Smith	Chief Executive		0-2.5	0-2.5	75-80	235-240	1,735	10	1,766	0
Ursula Wiltshire	Director of Quality and Innovation		0-2.5	2.5-5	30-35	100-105	0	0	0	0

Note: Lay members do not receive pensionable remuneration.

Workforce Remuneration: Multiple Pay
Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid director/member of the OCCG Board in the financial year 2016-17 was £160-£165k (2015-16 was £160k to £165k) on an annualised basis. This was 3.5 times (2015-16 3.6 times) the median remuneration of the workforce, which was £46,951 (2015-16 £45,070).

In 2016-17, no employees (2015-16 no employees) received remuneration in excess of the highest paid director/member of the OCCG Board. Remuneration ranged from £13,000 to £162,000 (2015-16 £3,000 to £160,000).

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

David Smith
Accountable Officer
XX May 2017

Staff Report

Staff sickness absence

Below outlines OCCG's sickness absence data from 1ST April 2016 to 31st March 2017.

	2015	2016	2017
Total Days lost (Absence FTE - days)	791	866	945
Headcount (Yearly Average)	114	126	129
Average Working Days Lost per head	6.9	6.8	7.3
Absence % FTE	2.55%	2.67%	2.82%

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 supported by the provision of HR advice and training sessions for all line managers on the effective management of sickness absence.

We also proactively promote the health and wellbeing of staff through a programme of health and wellbeing initiatives. Events are organised throughout the year and have included a Zumba taster session, Olympic Sports Day, Christmas decoration competition, Christmas quiz, introduction to mindfulness session and cycle to work initiative. The work is supported by a number of health and wellbeing champions and was shortlisted for an Oxfordshire Sports Award for Active Workplace.

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

Staff composition

OCCG has a workforce comprised of employees from a wide variety of professional groups. At the end of 2016/17 OCCG employed 130 staff (headcount), of which 91 were women and 39 men. As of 31 March 2017, the Board of OCCG was made up of 4 women and 8 men. Below is a breakdown of gender analysis. The membership body of OCCG is made up of all 72 (as at 31 March 2017) GP practices within Oxfordshire; a breakdown of membership by gender is not available.

The below table outlines the gender breakdown of staff:

	Female Headcount	Male Headcount	Total Headcount
CEO and Board	4	8	12
Very Senior Managers including GPs	11	15	26
All other Employees	76	16	92
Total Employees	91	39	130

The below table shows Average number of people (headcount) employed by OCCG, which equated to an average of 92.54 whole time equivalent staff.

	Total Number	2016/2017 Permanently employed Number	Other Numbers	2016/2017 Total Number
Total		129	27	156
Of the above: Number of whole time equivalent (WTE) people engaged on capital projects	0	0	0	0

Expenditure on consultancy
Expenditure on consultancy was £940k in 2016/17 (£568k in 2015/16) as per Note 5 to the Accounts page **XX.**

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

i) For all off payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than 6 months:

	Number
Number of existing engagements as of 31 March 2017	2
Of which, the number that have existed:	

For less than one year at the time of reporting	2
For between one and two years at time of reporting	0
For between two and three years at time of reporting	0
For between three and four years at time of reporting	0
For four years or more at the time of reporting	0

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

ii) For all new off payroll engagements between 1 April 2016 and 31 March 2017, 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 2016 and 31 March 2017	6
Number of new engagements which include contractual clauses giving OCCG the right to request assurance in relation to income tax and insurance obligations	6
Number for whom assurance has been requested	6
Of which:	
Assurance has been received	6
Assurance has not been received	0
Engagements terminated as a result of assurance not being received or ended before assurance was received.	0

iii) For any off payroll engagements of board members and / or senior officials with significant financial responsibility between 1 April 2016 and 31 March 2017.

	Number
Number of engagements of board members and senior officials with significant financial responsibility during the year	0

Significant financial influence:

	Number
Number of individuals that have been deemed board members and / or senior officials with significant financial responsibility during the year. This figure should include both off-payroll and on-payroll engagements	5

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

Exit Packages 2016/17

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

Exit Packages 2015/16

Exit packages cost (inc special payment element	Compulsory redundancies Number	Compulsory redundancies £s	Other agreed departures Number	Other agreed departures £s	Total Number	Total £s	Departures where special payments have been made Number	Departures where special payments have been made £s
Less than £10,000	0	0	0	0			0	0
£10,001 to £25,000	1	20,344	0	0	1	20,344	0	0
£25,001 to £50,000	0	0	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0	0	0
Total CCG	1	20,344	0	0	1	20,344	0	0

Ill-health Retirements

	2016/17 Number	2015/16 Number
Number of persons retired early on ill health grounds	0	0
Total additional pensions liabilities accrued in the year	0	0

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

Analysis of Other Agreed Departures

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

	2016/17 Other Agreed Departures Number	2016/17 Other Agreed Departures £	2015/16 Other Agreed Departures Number	2015/16 Other Agreed Departures £
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of service*	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total CCG	0	0	**0**	**0**

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

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

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

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

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

The Remuneration Report would include the disclosure of exit payments payable to individuals named in that Report. There were none during 2016/17.

Staff Policies

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

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

OCCG has developed a Health and Wellbeing Policy and has an active Health and Wellbeing Group which is responsible for the implementation of this policy. Events are held throughout the year with a large number of staff participating. Events have included fund raising activities, holding lunch time taster exercise sessions, introduction to mindfulness and know you numbers session where staff had weight, blood pressure and cholesterol measured with advice and support provided by a GP. The CCG came runner up in the Active Workplace category at the Oxfordshire Sports Awards in January 2017.

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

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

Managers also hold regular one-to-one meetings with staff and the values based appraisal system, which was introduced this year, ensures all staff work towards clearly defined personal objectives and standards of behaviour which are supported with learning, training and development opportunities detailed in individual Personal Development Plans.

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

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

Disability information
OCCG has developed an integrated approach to delivering workforce equality so it does not have a separate policy for disabled employees or for any other protected characteristics. Equalities issues are incorporated in policies covering all aspects of the employee lifecycle ranging from recruitment to performance. Our aim is to provide an environment in which all staff are engaged, supported and developed throughout their employment and to operate in ways which do not discriminate our potential or current employees by virtue of any of the protected characteristics specified in the Equality Act 2010. We are also committed to supporting our employees to maximise their performance including making any reasonable adjustments that may be required on a case by case basis.

We are committed to implementing the new Workforce Race Equality Standards (WRES) and will work with those organisations we commission services from and partners to ensure employees from black and ethnic minority backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Our 2016 WRES return is available on our website: http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2015/06/2016-OCCG-WRES-Reporting.pdf

Health and safety
We recognise that the maintenance of a safe work place and safe working environment is critical to our continued success and accordingly, we view our responsibilities for health, safety and welfare with the upmost importance. OCCG requires all workers to equally accept their responsibilities as part of the development of a true safety culture and we aim to ensure the achievement of high standards in relation to the provision of health and safety arrangements and the continued development of the safety culture and the well-being of staff.

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

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

Auditable elements
Please note that the elements of this remuneration and staff report that have been subject to audit are the analysis of staff numbers and gender analysis and related narrative notes on pages 71, the tables of salaries and allowances of senior managers and related narrative notes on page 65 and 66, pension benefits of senior managers

and related narrative on pages 67 and 68, exit packages and related narrative on pages 75 and 76 and the pay multiples and related narrative notes on page 67.

Parliamentary Accountability and Audit Report

Oxfordshire Clinical Commissioning Group is not required to produce a Parliamentary Accountability and Audit Report but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report. For 2016/17 there is nothing to disclose apart from losses as outlined below. An audit certificate and report is also included in this Annual Report at **[insert page reference when collated with Annual Accounts].**

The total number of NHS Clinical Commissioning Group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2016-17 Number	**Total Value of Cases 2016-17 £'000**	Total Number of Cases 2015-16 Number	Total Value of Cases 2015-16 £'000
Administrative write-offs	4	50	7	287
Fruitless payments	0	0	0	0
Store losses	0	0	0	0
Book Keeping Losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	0	0	0	0
Claims abandoned	0	0	0	0
Total	**4**	**50**	**7**	**287**

There are no cases exceeding £300,000 in 2016/17
There were no special payments made in 2016/17

Glossary of Terms

Alternative Medical Provider Services (APMS): This contract type allows non-NHS and private providers to bid to run GP practices.

Ambulatory Emergency Care Pathways: suitable patients can be seen and assessed by emergency clinicians and potentially started on treatment; but then discharged into the community, so avoiding unnecessary admission to hospital

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

Clinical Chair: medical doctors at the head of the Clinical Commissioning Groups.

Commissioning: buying hospital and other health services on behalf of patients

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

Domiciliary Care: a domiciliary carer visits a person in their own home to help with any daily activities which the patient cannot manage safely manage on their own, for example, bathing or getting dressed

Emergency Assessment Unit: this is a short-stay ward in a hospital where medical teams can assess the condition of patients admitted as an emergency before deciding on the most appropriate care and treatment for them

General Medical Services (GMS): The GMS contract is a UK-wide contract between general practices and primary care organisations for delivering primary care services.

GP Federation: a group of GP practices which come together to provide a greater range of services to patients in their local area

Health and Wellbeing Board (HWB Board): key leaders from the health and social care services work together to improve the health and wellbeing of their local population and reduce health inequalities

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

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

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

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

National Institute for Clinical Excellence: provides national guidance and advice to improve health and social care. It aims:

- to help medical practitioners deliver the best possible care
- to give people the most effective treatments based on the latest evidence
- to provide value for money
- to reduce inequalities and variation

Neighbourhood Access Hubs: patients unable to get an urgent GP appointment at their practice, will be offered an appointment at a nearby healthcare facility, with a local GP or nurse with access to their medical records

Non-elective Admissions: unplanned, often urgent admission to hospital (often via A&E)

Optometrists: specialists trained to examine the eyes to detect defects in vision, signs of injury, diseases or abnormality and problems with general health

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

Oxford Health NHS Foundation Trust (OHFT): OHFT provides physical, mental health and social care for people of all ages across Oxfordshire, Buckinghamshire, Swindon, Wiltshire, Bath and North East Somerset. It's services are delivered at community bases, hospitals, clinics and people's homes. We focus on delivering care as close to home as possible.

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

Patient Participation Groups (PPG): patient representatives from a local family doctor practice who advise and inform the practice on what matters most to patients and to help identify solutions to problems as a 'critical friend'

Personal Medical Services (PMS): a locally agreed contract between NHS England and a GP practice which offers local flexibility in the range of services provided by the practice and the financial arrangements

Prime Minister's GP Access Fund: £50m government funding, announced in late 2013, to find new and innovative ways of ensuring patients can see their GP seven days a week

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

QIPP: Quality, Innovation, Productivity and Prevention - a national, regional and local programme designed to support NHS organisations to improve quality of care while making savings which can be reinvested in the NHS

Quality Premium: is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services they commission and for associated improvements in health outcomes and reducing inequalities

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

Reablement: helping people with poor physical or mental health to learn or re-learn the skills necessary for daily living so they are not dependent on home care

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

South Central Ambulance NHS Foundation Trust (SCAS): SCAS provides and accident and emergency service to respond to 999 calls; the NHS 11 service for when medical help is needed fast but not a 999 emergency and a non-urgent patient transport service. It covers the counties of Berkshire, Buckinghamshire, Hampshire and Oxfordshire.

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

Transformation Board: The Oxfordshire Transformation Programme has been set up to drive forward the transformation of the health and social care system in the county. The board is chaired by the Chief Executive of Oxford Health NHS Foundation Trust and is made up of NHS and social care leaders

Urgent Care: treatment of injuries or illnesses requiring immediate care, but not serious enough to need an A&E visit.