Purpose and Executive Summary:
The following paper includes the Performance Report and the Accountability Report sections of the Annual Report for 2019/20

In response to the COVID-19 pandemic, guidance for annual reporting requirements was issued by the Department of Health and Social Care on the Accounting Manual for 2019/201. In the new guidance there is an ‘option to omit’ some information; this includes the omission of a full performance analysis and sickness absence data.

As such the performance report is an overview of key performance information and a summary of the key issues and risks of OCCG not a full performance analysis as in previous years.

The Accountability Report consists of:

- A corporate governance report
- A Remuneration and Staff Report
- A Parliamentary Accountability and Audit Report

The Annual Report, along with the annual accounts, will be submitted to NHS England by 25 June.

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To note, there are still some outstanding performance outcome information and finance figures which will be included in the final draft. As well as changes made following any auditor recommendations.

**Engagement: clinical, stakeholder and public/patient:**
Not applicable

**Financial Implications of Paper:**
Not applicable

**Action Required:**
To approve the report on the basis of a detailed review by the Audit Committee and final approval be delegated to the Chair of Audit Committee and the Director of Governance.

**OCCG Priorities Supported** (please delete tick as appropriate)
- [x] Operational Delivery
- [x] Transforming Health and Care
- [x] Devolution and Integration
- [x] Empowering Patients
- [x] Engaging Communities
- [x] System Leadership

**Equality Analysis Outcome:**
Not undertaken although it reports on the actions the CCG takes to ensure equality.

**Link to Risk:**
Not applicable.

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**Date of Paper:** 2 June 2020
Oxfordshire Clinical Commissioning Group:
Annual Report 2019/20
Foreword from Clinical Chair

I am pleased to present NHS Oxfordshire Clinical Commissioning Group’s (OCCG) annual report and accounts for 2019/20. During the year we have made real progress in the way healthcare is delivered in the county. However during the time of writing this report we are facing an unprecedented challenge with the COVID-19 pandemic. The position relating to COVID-19 has been dynamic to say the least. OCCG, together with other NHS organisations and the Local Authorities in Oxfordshire have been working very closely to ensure our response to COVID-19 has been effective and coordinated and continues to be so as we move forward into 2020/21.

I would like to take this opportunity to thank everyone involved in this public health crisis: staff on the frontline, staff in our NHS and local authority organisations as well Oxfordshire’s voluntary, third sector partners and local groups whose efforts to support staff and the community have been vital. For this, I am very grateful.

Whilst we are dealing with the COVID-19 pandemic currently, this annual report is about the past year April 2019 to March 2020. It is not as detailed as previous years given staff resources have been deployed to the COVID-19 response. However we must take this opportunity to recognise the progress made across health and social care in the past year and the positive changes that have been made to improve patient outcomes.

This work includes the development of more sustainable general practice; advances in supporting older people with chronic respiratory conditions in the community; better outcomes for people with diabetes; better cancer detection and treatment; improved access for children and young people to mental health support through schools and the introduction of social prescribing to help people to take a holistic approach to their health and wellbeing, to state just a few.

Despite the COVID-19 pandemic we must not lose the progress made last year and we must continue to work in an integrated way across health and social care, something which has progressed significantly throughout the past few months. We need to do this across Oxfordshire and our wider integrated care system across Buckinghamshire, Oxfordshire and Berkshire West. We must embed changes that we have made in the past year as well as any beneficial changes in the way services have been provided during the COVID-19 pandemic. If we do this we will make better use of our resources and continue to improve the health and wellbeing and experiences of our patients and the wider public.

Dr Kiren Collison
Clinical Chair
Performance Report

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

What we do

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

OCCG is a member organisation of 68 GP practices in Oxfordshire; we work with local people, voluntary sector organisations and partners OCC, local District Councils, GPs and Primary Care Networks, Oxford University Hospitals NHS Foundation Trust (OUH), Oxford Health NHS Foundation Trust (Oxford Health) and South Central Ambulance NHS Foundation Trust (SCAS).

OCCG is also part of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) which covers a population of 1.8 million, three Clinical Commissioning Groups (CCGs) including OCCG, six NHS Trusts, 14 local authorities and 166 GP practices, working together as 45 Primary Care Networks.

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

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

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

During the reporting financial year 2019/20 the COVID-19 crisis ensued. The pandemic has had a significant impact on public sector resources; the NHS is under considerable pressure, with new and changing working arrangements affecting teams in organisations to varying degrees.

In response to the COVID-19 pandemic, guidance for annual reporting requirements has been issued by the Department of Health and Social Care on the Accounting Manual for 2019/20. In the new guidance there is an ‘option to omit’ some information; this includes the omission of a full performance analysis and sickness absence data. As such the following performance report is an overview of key performance information; a note from the new Accountable Officer giving his perspective on the performance of the organisation and a summary of the key issues and risks of OCCG.

The information above is from the Joint Strategic Needs Assessment for Oxfordshire 2020 which provides information about the county's population and the factors affecting health, wellbeing, and social care needs. It brings together information from different sources to create a shared evidence base. This informs OCCG’s strategy and supports its service planning and decision-making. To read more about the health needs of Oxfordshire’s population visit Oxfordshire County Council website: http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment

Overview from Dr James Kent, Accountable Officer

Summary of performance
Improving the health and wellbeing of people in Oxfordshire

In 2019, the Health and Wellbeing Board agreed a new Prevention Framework for the county. Demand for health and care services is rising; nationally and locally there are workforce issues and financial resources are struggling to keep pace. The framework looks at how, across Oxfordshire, the NHS and local authorities together with the voluntary sector need to work differently, shifting to a more pro-active approach to prevention as outlined below:

<table>
<thead>
<tr>
<th>PREVENT illness</th>
<th>REDUCE the need for treatment</th>
<th>DELAY the need for care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing illness and keeping people physically and mentally well, e.g. being active, breathing clean air, having social connections</td>
<td>Reducing impact of an illness by early detection e.g. cancer screening, and preventing recurrence e.g. lowering blood pressure or cholesterol to prevent another stroke</td>
<td>Soften the impact of an ongoing illness and keep people independent for longer</td>
</tr>
<tr>
<td>(primary prevention)</td>
<td>(secondary prevention)</td>
<td>(tertiary prevention)</td>
</tr>
</tbody>
</table>

The focus of the framework covers the wider determinants of health including:

- Lifestyle factors: particularly obesity, poor diet, lack of physical activity, smoking and alcohol
- Built environment and socioeconomic factors including Healthy Place Shaping, loneliness, low income and affordable warmth
- Health care factors and how prevention initiatives can be embedded in all parts of the health and care system.

As part of delivering the Oxfordshire Health and Wellbeing Strategy, the county’s health and care partners agreed a new approach
to planning health, care and wellbeing services using 'population health management', which features in the NHS Long Term Plan. A framework was developed to review and plan for future care needs in the county and is intended to be delivered by working in localities with the local residents, communities and stakeholders, including local councils.

The first area where this has been applied is in the OX12 postcode area (Wantage, Grove and surrounding villages). Over the course of 12 months health and care partners worked together with some representatives of the local community to apply the framework; a summary is available here. The new approach demonstrated a clear commitment to partnership working in Oxfordshire as well as extensive stakeholder engagement and co-design with stakeholders and wider members of the public throughout all stages of the health needs framework. The project showed that when compared with both Oxfordshire and the rest of England, the population of the OX12 area is relatively healthy, relatively affluent and well served in terms of services. However, that does not mean that OX12 is without its challenges or that the population of OX12 does not experience difficulty accessing services. The outputs from applying the framework were grouped under four key themes as agreed with stakeholders:

- Promoting and developing health and wellbeing across all life stages
- The impact of a changing population on demand and need
- Making best use of community resources
- Travel and transport

Work will continue this year to address those gaps and issues identified through the project. The H&WB Board agreed the next application of the framework will be in Banbury. This work commenced at the beginning of 2020 but due to the COVID-19 pandemic the work was paused and resource was redeployed to support Oxfordshire’s response to the crisis.

**Developing a more personalised primary care service**

In 2019 the NHS Long Term Plan (LTP) set out an ambitious programme of change for primary care and community services. Primary Care Networks are based around a GP registered list of approximately 30,000 – 50,000 patients, including GP practices and other partners in community and social care. In Oxfordshire there are 19 PCNs covering the whole Oxfordshire population which were established in July 2019. The networks offer services on a scale which is small enough for patients to get the continuous and personalised care they value, but large enough – in their partnership with others in the local health and care system - to be resilient and sustainable.

The PCNs will work with the Patient Participation Groups (PPGs) of their member GP practices and local communities in making plans, identifying priorities and seeking feedback on how services are delivered. To help support this approach, OCCG has commissioned Healthwatch Oxfordshire to develop and support PPGs working in alliance with their PCN. This will enable representation to be more diverse and reflect more accurately the voice of service users in each area. As PCNs develop, they will communicate with OCCG about their
Supporting people with respiratory conditions in the community

In November 2018 OCCG launched an Integrated Respiratory Team (IRT) pilot project in North Oxfordshire and Oxford city to support people with long term respiratory conditions such as Chronic Obstructive Pulmonary Disorder (COPD) and asthma. The project enhances existing community, hospital-based and primary care services by providing a consultant to work in the community alongside additional respiratory nurses and physiotherapists working with respiratory GPs, a dedicated psychologist, a pharmacist, dedicated smoke-free advisor and a specialist in palliative care support. The project, which is also being supported by pharmaceutical company Boeringher Ingelheim, is staffed by NHS clinicians and other professionals from OUH, Oxford Health and local GPs.

At the end of October 2019, 31 community respiratory clinics for adults have been held in the pilot areas, with 322 attended appointments. The average wait time for a first appointment in the community clinic is less than seven weeks compared with just over 11 weeks for a first COPD hospital outpatient appointment at OUHFT. The community clinic also has fewer patients not turning up for appointments and has received positive feedback from patients.

People with long-term respiratory conditions who are admitted to hospital remain under review by a 'virtual ward' for 30 days after they are discharged. So far 263 patients have been reviewed under the virtual ward: 26 per cent of them have been re-admitted and 74 per cent have not.

Suspected CANcer (SCAN) Pathway

The SCAN service continues to help patients who present with 'vague' symptoms such as weight loss and tiredness. Before the launch of the SCAN pathway three years ago, GPs did not have a way to get rapid investigations for patients with 'non-specific' symptoms, with patients going back and forth between their GP and the hospital many times until a diagnosis was made.

The SCAN pathway aims to lower the referral threshold for suspected cancer and help those patients with ‘non-specific’ symptoms. It involves rapid access to Computed Tomography (CT) and laboratory tests (blood and faeces tests), with possible further tests if needed. The aim is to reach a diagnosis and begin treatment faster than previously happened.

Since its launch, 145 patients who underwent a CT scan were found to have cancer (9.4% of patients who met the criteria for investigation) and were then able to start appropriate treatment quickly. In addition to CT scans, the team uses laboratory tests to detect cancer and other illnesses, which have included heart conditions, Addison's disease and hernias.

The SCAN Pathway Team were recognised for their hard work in detecting cancer and other serious illnesses in patients in Oxfordshire last year when they won the Improvement and Innovation category at this year's Oxford University Hospitals 'Staff Recognition Awards' in December.
OCCG has been working hard with OUH to improve cancer waiting times; four out of the eight constitutional targets were met (see page 17 for more detail on performance figures). We will continue to work with OUH to develop and implement a plan to improve cancer waiting times over the next year.

**Improving diabetes care and prevention**

It is estimated that around 56,000 people in Oxfordshire are currently at risk of developing Type 2 diabetes which can lead to other serious conditions including strokes, heart diseases, limb amputation and early death. However, in most cases it is preventable and also reversible if caught early. The NHS’ National Diabetes Prevention Programme offers a local service to people who are at risk of Type 2 diabetes. The programme is designed to stop or delay the onset of the disease through education on lifestyle choices, advice on weight loss through healthier eating and physical activity. Between June 2017 (when the programme was launched in Oxfordshire) and the end of January 2020, 5,358 people at risk of developing Type 2 diabetes have been referred into the programme. The average weight loss between an initial assessment and six months into the programme is between 2.5kg and 3.5kg.

Oxfordshire also has around 30,000 people who have Type 1 diabetes\(^2\) (10 per cent) and Type 2 diabetes (90 per cent) and extra investment has been put into a number of initiatives to support them, including structured education. Structured education is recommended under NICE guidelines for all diabetes patients to improve their understanding of their condition and provide them with the knowledge, skills and confidence to be able to manage it effectively. In Oxfordshire the number of people with Type-1 diabetes attending courses within 12 months of diagnosis was 12.5 per cent in 2017 (which is the latest information available) up from five per cent in 2016 and better than the England figure of 7.2 per cent. People with Type 2 diabetes attending structured education within 12 months of diagnosis was 21.9 per cent in 2017 (up from 7.6 per cent in 2016) – compared with the England figure of 12.4 per cent in 2017.

**Developing maternity services at the Horton General Hospital**

Following a referral to the Secretary of State (SoS) by the Oxfordshire Joint Health Overview and Scrutiny Committee on the decision by OCCG’s Board in September 2018 to create a single obstetric unit for Oxfordshire OCCG and OUH developed a programme of work to address the recommendations made by the Independent Reconfiguration Panel. This included engaging with women across Oxfordshire, Northamptonshire and Warwickshire on their experience of using maternity services during the time of the temporary closure of obstetric services. The work included a survey, focus groups and interviews with women and their partners. The full report and analysis of the engagement is published and available [here](#).

Women reported their experience of ante-natal care, labour and childbirth and post-natal care. The focus of the project was to help make

\(^2\) Type 1 diabetes isn't linked with age or being overweight and is not reversible.
decisions about the Horton maternity services, but a number of issues were highlighted relating to wider maternity services, including difficulties in accessing the John Radcliffe site while in labour, the importance of having as much support as possible available locally at the Horton General Hospital so that even if the birth takes place in Oxford, the ante-natal and post-natal care should be in Banbury and that more information about choices and access to services was available to women. As a result, OCCG is working with OUH on an implementation plan to improve mothers’ and partners’ experiences and enhance access to maternity services (particularly for the population in the Horton catchment area which includes women in Warwickshire and Northamptonshire) by introducing:

- A dedicated hotline for women in labour and their families to navigate the John Radcliffe site and use priority parking in an emergency. This is in addition to current work to address travel and parking issues at the John Radcliffe Hospital site.
- An expansion of services available at the Horton Midwife Led Unit (MLU) or virtually to enable women to receive most of their maternity care closer to home; and increased facilities for birth partners to stay overnight at the John Radcliffe Hospital.
- Better information for women on the choice of options available, including joint working and strengthening links with South Warwickshire NHS Foundation Trust to ensure Warwick Hospital is an attractive option for women in the North Oxfordshire area.

This work, alongside a more detailed appraisal of options; review of Clinical Senate recommendations; review of staff and transfer models as well as interdependencies with other services informed the decision made by the Board in September 2019 to have one obstetric unit at the John Radcliffe Hospital in Oxford and a Midwife Led Unit at the Horton General Hospital in Banbury for the foreseeable future. It was agreed that OCCG together with health and care partners will regularly review population health and care needs and change services as needed.

**Ensuring there is parity of esteem for patients**

There is a need to ensure mental health is given equal priority to physical health by health service commissioners and to achieve national targets which meet the needs of the population. To bring about this ‘parity of esteem’, decisions must be made across the whole health and care system to examine priorities in relation to needs for the future.

Positive steps to tackle the issue of the imbalance of resources for mental health services in Oxfordshire are underway through the development of a mental health investment plan between OCCG, OHFT, the Oxfordshire Mental Health Partnership and other stakeholders.

A phased proposal to begin to close the funding and resources gap is being implemented. This year (2019/20) OCCG exceeded the requirements of the mental health investment standard and supported the county’s voluntary sector providers on a range of initiatives through additional funding. It has also invested in mental health crisis support, mental health practitioners within GP surgeries and in GP health checks for adults with serious mental health issues and people aged 14 years and over with learning disabilities.

Colleagues within Oxfordshire have worked with local communities to engage and involve them in decisions about a range of mental health services and plans. For example: in designing the new Mental Health In Schools service; the primary care mental health link workers
service; a new crisis safe haven service which offers crisis support, signposting, safety planning and listening support to people experiencing a mental health crisis; recommissioning the carers’ support services and dementia support services; talking to campaign groups to develop services and being part of the Oxfordshire Co-Production Board where local people from different care groups can be informed of current projects and influence the shape of delivery.

**Improving mental health services for children and young people**

In 2018 OCCG secured NHS England funding to pilot four new mental health support teams (MHSTs) in Oxfordshire schools. Each team covers 8,000 students. The first phase of the pilot was implemented in 2019 and is well underway with two teams established in Oxford City covering all primary and secondary schools. Plans for two additional teams were launched in October with primary and secondary schools in the Banbury and Bicester area. The schools were chosen following a needs assessment and agreed by the multi-agency Children and Adolescent Mental Health Service (CAMHS) Assurance Board. This methodology will be used to recruit new schools if and when OCCG is successful in further bidding to NHS England.

Mental health support teams consist of specially trained staff linked to groups of schools. They offer individual and group help to young people with mild to moderate mental health issues, including anxiety, low mood and behavioural difficulties. The new teams also carry out targeted group sessions and whole school assembly work and, where appropriate, can offer group parenting classes that aim to help parents with children’s social and emotional health issues.

The MHSTs are the link between the NHS and schools as they work closely with the designated school mental health lead. The teams are part of the Single Point of Access to CAMHS, meaning that where a child needs referral to more intensive services they will be referred direct. This will mean that schools will find it much easier to contact and work with mental health services. The teams are also supporting schools to develop their whole school working and pastoral approach to mental health and wellbeing. The new teams will be managed by Response from the Third Sector Partnership but based in the local area. They will work alongside other people who provide mental health support including school nurses, locality and community support services, educational psychologists, school counsellors, voluntary and community organisations and social workers.

The pilots are subject to quarterly assurance monitoring by NHS England and will be part of a national evaluation.

**Tackling urgent care pressures in the county**

Health and social care professionals from across the system and the voluntary sector again came together over the winter months to deliver responsive and joined-up services throughout the season. By building on last year’s collaborative working, the team also worked to improve quality and performance of emergency and urgent care in the area. Winter is a high-pressure season for health and social care services, with the colder temperatures and harsher weather conditions leading to increased demands on GPs and Emergency Departments as flu
season begins. However, with demand for urgent care services increasing year on year, the team will continue throughout the year to
develop better ways of working to support urgent care services in the county and improve access and outcomes for patients.

The priority was to ensure that people who needed medical treatment were able to access services to get the care they need and when
people no longer need hospital treatment, to make sure they are looked after in the most appropriate place, whether that be at home or in
the community. The work was supported by an Oxfordshire wide communications plan which urged people to have a ‘winter plan’ for
themselves and their family so that they know what they need to do to keep as well as possible, what they could do if they become unwell,
and how they could look after their elderly neighbours who may not be able to look after themselves. It also raised awareness of alternative
services to A&E, use of pharmacies and encouraged people to get their flu jab, if they were eligible.

As part of the work, South Central Ambulance Service NHS Foundation Trust, SCAS, developed a range of new urgent care pathways with
colleagues from across Oxfordshire’s health and social care providers to ensure more patients get direct access to the appropriate care and
specialists they need, rather than be taken initially to an Emergency Department at either the John Radcliffe or Horton Hospitals.

The new urgent care pathways mean that ambulance staff on the road have direct access to specialists and clinical support, some of which
is available 24/7. By working together more efficiently with partners, admissions to hospital can be avoided for some patients who previously
would have been taken in, as well as bypassing Emergency Departments for some patients for whom it has already been identified which
specialist consultant or service they need.

Work also continues to expand the Emergency Department (ED) at the John Radcliffe Hospital site; the new building will provide a better
use of space, more diagnostic equipment and improved dignity and privacy for patients as well as improved turnaround times for
ambulances. The expansion is due to be completed early summer 2020.

**Social prescribing**

Social prescribing has gained momentum over recent years nationally and locally in Oxfordshire. It has now received further backing and
funding from NHS England, through the Long Term Plan. Social prescribing enables GPs and other healthcare professionals to refer
patients to a link worker who can help them to find personal solutions to improve their health and wellbeing, often through voluntary and
community services.

In Oxfordshire, the Mind charity, part of the Oxfordshire Mental Health Partnership, is working with GP practices to encourage and enable
patients to link in with existing support services, use the support available in their local community, and develop tools to increase their ability
to manage their own wellbeing. Patients are referred to the Wellbeing Workers service which can:

- help people identify what is important to them
- offer time, space and support for them to work out the positive changes they want to make
• tell them about relevant services they can access to improve their wellbeing and support them with making referrals
• support them to reach their goals.

Improving Quality

Improving the quality of healthcare provided to people in Oxfordshire is at the heart of OCCG’s work. We work together with our partners to improve patient experience, improve the quality of services and learn from incidents to reduce the risk of them happening again. OCCG and partners do this in many ways; below gives a flavour of some of the work undertaken to improve quality, however more will be available on our website in July 2020 with the publication of OCCG’s Quality Committee Annual Report.

Medicines optimisation

Medicines optimisation enables people to get the best possible outcomes from their medicines by supporting patients, carers and families to make decisions about which medications they should take to feel as well as possible.

In 2019/20, OCCG continued to support appropriate prescribing through review and implementation of guidelines, collaborative work with providers, the introduction of new pathways and the review of governance arrangements.

Prescribing was monitored to identify where review was needed and data used to inform where prescribing in OCCG differed from other CCGs with similar populations. In addition, there was further collaborative working with colleagues across the care system, including medicines optimisation teams from neighbouring CCGs, regular meetings with pharmacists employed by GP practices and primary care networks (PCNs). Many of the new PCNs, as well as individual practices, now employ their own pharmacist(s); OCCG set up a network which brings them together with other NHS colleagues to talk about topical issues. The meetings continued to be well attended and feedback remained very positive. Although working with the PCNs is new, OCCG has always worked closely with colleagues in secondary care to ensure formularies and guidelines are aligned. OCCG is already seeing the benefits of more joint working and looks forward to further collaboration across the Integrated Care System.

As in previous years OCCG supported GP practices with the Prescribing Incentive Scheme (PIS), part of which required them to use the PINCER risk stratification tool, an online intervention tool, has helped to reduce medication errors in primary care. While medicines safety was the main focus of the PIS, the team also supported practices to make cost savings. These included reviewing the use of items such as ketone testing strips, sip feeds, and dressings. The prescribing dashboard continued to be updated monthly via the OCCG website for practices to track their prescribing targets, achievements and priorities.

Addressing health inequalities

OCCG continues to facilitate the Health Inequalities Commission implementation group, which includes NHS, local authority and voluntary
sector partners. Work is complete to address the 60 recommendations made by the Commission in December 2016; however work continues to tackle health inequalities; the group has been focusing on a ‘health in all policies’ approach during the past year.

One of the recommendations was for an innovation fund to allow volunteer organisations to tackle health inequalities. Funding has come from OCCG and all local authorities in Oxfordshire. The implementation group partnered with Oxfordshire Community Foundation (OCF) and £24,000 was allocated to various community projects. The funding was awarded in three phases:

- The first phase was combined with the OCF Tampon Tax Fund and contributions were awarded to Aspire Oxfordshire for the Gym Bus; Ark-T for HerSpace workshops and self-care retreats; and Home Start Oxford for support to families.
- The second phase was combined with the OCF Loneliness and Isolation Fund. Sound Resource received funding for a singing project in Banbury and Bookfeast for a reading project.
- The third phase was combined with the OCF Community Friendship fund and money was awarded to My Life My Choice for a Gig Buddies project.

Further details can be found on the OCF website https://oxfordshire.org/grants

**Engaging the public and local communities**

OCCG believes that communicating and engaging with its local population is key to achieving its vision. The organisation is committed to putting the patient first and applying the principle of ‘No decision about me without me’ in its commissioning approach.

OCCG uses the NHS England Principles for Participation to guide its public involvement activities.

The population of Oxfordshire is diverse and each community has different needs. It is important for us to understand this diversity to ensure health services are planned properly and provide equity in terms of access, experience and outcomes for everyone.

OCCG tailors its engagement materials and activity to enable people with different needs to participate in the work of OCCG. For example, the contract for the provision of Luther Street Medical Centre, an NHS GP surgery in Oxford which provides specialist services to people who are homeless or vulnerably housed, was up for renewal. The medical centre also provides a range of other services including mental health services, advice on benefits and drugs and alcohol services. The primary care service delivered within the centre is commissioned by OCCG and provided by Oxford Health. To inform the procurement process OCCG sought to gather feedback and comments from patients and service users at Luther Street Medical Centre to plan and shape the services for the future, as well as those voluntary and charitable organisations that work with people who are homeless.

There was high satisfaction with the service among patients who stated that the service they received at Luther Street Medical practice was very good; doctors were responsive and ‘knew their stuff’ and the location was convenient. For more information on what was said please visit [here](#). OCCG underwent a formal procurement process for the provision of primary care medical services at Luther Street Medical
Practice and following an evaluation of the bids, the contract for the provision of Primary Medical Services for Homeless Patients was awarded to Oxford Health, the incumbent provider. The new contract started on 1 April 2020.

Work has also been undertaken providing information sessions about NHS cancer screening programmes for some black and minority ethnic community members. They talked about cervical and breast cancer screening and signs and symptoms. Health advice has also been provided with signposting support to Syrian families re-settling in Cherwell. With an interpreter, families were advised about registering with a GP and NHS dentist; other services to help with health issues; NHS screening programmes and information on how to stay healthy.

OCCG also worked with Oxford City Council to develop a new leaflet for people who live on boats in Oxford City to help them access health care services. Feedback from boat dwellers in Oxford City suggested there were issues in accessing GP services locally due to having no fixed address. The new leaflet was distributed to the boating community in Oxford and GP practices to ensure appropriate support for this community. The leaflet includes information on GP services and how to access them as well as what you need to register at a GP practice; NHS111, A&E and local pharmacy.

A fuller report on patient and public engagement activities will be available later in the year.

How does OCCG manage its money?

At the start of the year the CCG set its financial plans to deliver the objectives set by NHS England and planned to deliver a breakeven financial position. The CCG carried forward a cumulative historic surplus of £23.4m into 2019/20 none of which was requested to be utilised (drawn down) in the year. At the end of the year the CCG achieved a small surplus of £19k, which means that the CCG delivered against its financial plan. This will be added to the historic surplus and £23.4m will be carried forward for drawdown in future years.

For the financial year 2019/20, OCCG’s total funding was £958.7m. Of this, £943.8m was allocated for healthcare programmes and £14.9m for the CCG’s running costs. The CCG released £1.5m of the running cost allocation for use on healthcare as a result of savings made and this is reflected in the table below which summarises our budget (plan) and actual expenditure for 2019/20:
As set out in the 2019/20 NHS Planning Guidance, CCGs were required to set aside a contingency of 0.5% at the start of the year to provide a buffer to offset potential in-year pressures. This entire contingency was required in year to meet programme pressures.

OCCG has formal delegated responsibility from NHS England for GP Primary Care Commissioning and the CCG received an allocation of £96.8m in order to deliver this.

During the last quarter of 2019/20 the Covid-19 pandemic began to impact services. At the beginning of March NHS England declared COVID-19 a level four incident - the highest level of emergency preparedness planning. As such the NHS began a significant mobilisation to respond to the pandemic. OCCG claimed for £773k of additional revenue expenditure in March directly related to preparations for the pandemic and this was funded by additional allocation from NHS E. The expenditure related mainly to preparation in Primary care to enable remote management of patients and to enable management of Covid-19 positive patients.
in the community. There was also additional expenditure in relation to hospices and to the hospital discharge programme which was aimed at freeing up hospital capacity for the anticipated level of Covid-19 patients.

During the year, OCCG continued joint commissioning and pooled budget arrangements with OCC. There were two pooled budgets - the Better Care Fund (BCF) pool and the Adults with Care and Support Needs (ACSN) pool. New risk shares were agreed for each of the two pools during the year. OCCG’s contribution to the pooled budgets in 2019-20 was £171m while OCC contributed £222m.

For the next financial year 2020/21, OCCG was notified of a £38m increase to funding (£43m in 2019/20) and submitted a draft plan in early March 2020 based on this. However, in the light of the emerging pandemic response, the national planning process has been put on hold so that NHS resources could be focussed on the immediate emergency response. National arrangements have been put in place to ensure that NHS providers receive cash as required by means of a national block contracting arrangement through CCGs and also that independent sector provision was secured nationally to support NHS provision during the pandemic. These arrangements are in place until the end of July 2020 after which they will be reviewed with a view to returning to more usual commissioning and contracting arrangements.

In line with national policy direction for the NHS, Oxfordshire CCG continues to work more closely with the BOB ICS. Organisations now work more closely together to make choices and decisions about how the Oxfordshire pound (£) is spent. Improved system working across Oxfordshire and across the wider BOB ICS area will contribute to getting the best possible value from the Oxfordshire pound (£).

It is not yet clear what form the “new normal” for the NHS will take, post the Covid-19 pandemic but it is clear that both place (Oxfordshire) and system (BOB) based commissioning arrangements will continue to play a key role in the planning and delivery of NHS services.

**Constitutional Targets**

Below outlines the NHS constitutional targets OCCG has a duty to meet. The data is year-end unless noted with *; this performance data is based on 11 months data (April 2019 to February 2020) as March reports. Due to COVID-19 illness and the need to release capacity across the NHS to support the response, the collection and publication of data and official statistics was paused.
<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator</th>
<th>Target</th>
<th>OCCG achieved 19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to treatment waiting times for non-urgent consultant led treatment</td>
<td>Admitted and non-admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>92%</td>
<td>80.8%</td>
</tr>
<tr>
<td></td>
<td>Maximum two week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP</td>
<td>93%</td>
<td>95.0%</td>
</tr>
<tr>
<td></td>
<td>Maximum two week wait for first outpatient appointment for patients referred urgently with breast symptoms</td>
<td>93%</td>
<td>96.9%</td>
</tr>
<tr>
<td></td>
<td>Maximum one month (31 Day) wait from diagnosis to first treatment for all cancers</td>
<td>96%</td>
<td>92.4%</td>
</tr>
<tr>
<td></td>
<td>Maximum 31 day wait for subsequent treatment where the treatment is surgery</td>
<td>94%</td>
<td>89.9%</td>
</tr>
<tr>
<td></td>
<td>Maximum 31 day subsequent treatment where the treatment course is chemotherapy</td>
<td>98%</td>
<td>99.7%</td>
</tr>
<tr>
<td></td>
<td>Maximum 31 day subsequent treatment where the treatment course is radiotherapy</td>
<td>94%</td>
<td>98.6%</td>
</tr>
<tr>
<td></td>
<td>Maximum 2 month wait (62 day) wait from urgent referral to first definitive treatment for cancer</td>
<td>85%</td>
<td>73.0%</td>
</tr>
<tr>
<td></td>
<td>Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers</td>
<td>90%</td>
<td>61.0%</td>
</tr>
<tr>
<td>Cancer Waiting Times</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test waiting times</td>
<td>Patients waiting for a diagnostic test should have been waiting over 6 weeks from referral</td>
<td>1%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Category</td>
<td>Measurement</td>
<td>OUH</td>
<td>RBH</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>A&amp;E Waits</strong></td>
<td>Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&amp;E department</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The number of patients waiting longer than 12 hours on a trolley</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>OUH</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>RBH</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Delayed Transfers of Care</strong></td>
<td>Number of day delayed as % of occupied bed days</td>
<td>OUHFT</td>
<td>RBHT</td>
</tr>
<tr>
<td></td>
<td>OUHFT</td>
<td>3.5%</td>
<td>3.5%</td>
</tr>
<tr>
<td></td>
<td>RBHT</td>
<td>3.5%</td>
<td>6.2%</td>
</tr>
<tr>
<td></td>
<td>Mental Health - OHFT</td>
<td>3.5%</td>
<td>6.2%</td>
</tr>
<tr>
<td></td>
<td>Community hospital - OHFT</td>
<td>3.5%</td>
<td>9.3%</td>
</tr>
<tr>
<td><strong>Mixed Sex Accommodation</strong></td>
<td>The number or breaches of same sex accommodation</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>Dementia Diagnosis</td>
<td>67%</td>
<td>67%</td>
</tr>
<tr>
<td><strong>Cancelled Operations</strong></td>
<td>All patients who have had operations cancelled on or after the day of admission (including the day of surgery), for non-clinical reasons, to be offered another binding date withing 28 days, or the patients treatment to be funded at the time and hospital of the patients choice.</td>
<td>0</td>
<td>47 breaches</td>
</tr>
</tbody>
</table>
How does OCCG monitor performance?

The OCCG Board is responsible for discharging the duties of its constitution, which includes monitoring and scrutinising the performance of service providers. The Board receives an integrated performance report at the bi-monthly meetings in public. Formal committees of the Board scrutinise in more detail how OCCG and health providers are delivering contracted services; these are the Finance Committee, the Audit Committee, Oxfordshire Primary Care Commissioning Committee, the Quality Committee and the OCCG Executive Committee (for more information about the committees and their purpose please see page 30). In addition to the monitoring requirements outlined above, the Accident & Emergency (A&E) Delivery Board also has a role to play in monitoring performance. Its members include the chief operating officers and board level representatives from NHS organisations in Oxfordshire and OCC. The group aims to develop and maintain resilience across the urgent care services and improve the flow of patients through A&E, admission, treatment and discharge.

How is OCCG monitored?

NHS England has a statutory duty to undertake annual assessment of CCGs. This is undertaken using the Improvement and Assessment Framework (IAF), with the overall assessment derived from OCCGs’ performance against the IAF indicators, including an assessment of CCG leadership and financial management. Each CCG receives an overall assessment that places their performance in one of four categories: outstanding, good, requires improvement, or inadequate. OCCG received an overall rating of good in the last set of published assessments for 2018/19.

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

Managing risk

Reducing risk across the health system is a priority for OCCG to ensure patients receive high standards of care. Risks are events or scenarios that can hamper OCCG’s ability to achieve its objectives. These risks, divided into strategic and operational, are identified, assessed and managed by the organisation and reviewed at every OCCG Board meeting in public. They are continually reviewed at Board committee meetings including the Audit Committee, the Finance Committee, the Oxfordshire Primary Care Commissioning Committee, the Quality Committee and the OCCG Executive Committee. Board Committees and OCCG directors review all risks on a bi-monthly basis. The report on OCCG’s principal, strategic and operational risks and mitigations as of 31 March 2020 can be found on OCCGs website here.

Dr James Kent
Accountable Officer
June 25 2020
Accountability Report

Corporate Governance Report

Members Report

Membership Practice Localities and Profiles

North East Oxfordshire:
The North East Locality is made up of 7 GP practices covering the registered population. The GP Locality Clinical Director was Dr Will O’Gorman until 31 March 2020. The Deputy Locality Clinical Director is Dr Sam Hart. The 7 member practices in the North East Locality are:

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

North Oxfordshire:
The North Oxfordshire Locality is made up of 11 GP practices covering the registered population. The GP Locality Clinical Director is Dr Shelley Hayles who is supported by Deputy Locality Clinical Director Dr Neil Fisher. The 11 member practices in the North Oxfordshire Locality are:

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

*Horsefair Surgery merged with Banbury Cross Health Centre in May 2020.

Oxford City:
The Oxford City Locality is made up of 20 practices covering the registered population. The GP Locality Clinical Director is Dr David Chapman who is supported by the following Deputy Locality Clinical Directors, Dr Merlin Dunlop (until 6 April 2020), Dr Karen Kearley and Dr Andy Valentine. The 20 member practices which make up the Oxford City Locality 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 (including Kennington Health Centre)
7. Hedena Health (formerly known as Bury Knowle Health Centre and includes Wood Farm Health Centre and Marston Medical Centre)
8. Donnington Medical Partnership at Donnington Health Centre
9. Cowley Road Medical Practice (formerly known as East Oxford Health Centre)
10. Hollow Way Medical Centre
11. Jericho Health Centre
12. King Edward Street Medical Practice
13. Luther Street Medical Centre
14. Observatory Medical Practice (formerly known as Jericho Health Centre - Dr Kearley)
15. St Bartholomew's Medical Centre (including South Oxford Health Centre)
16. St Clement's Surgery
17. Summertown Health Centre
18. Temple Cowley Health Centre
19. The Leys Health Centre
20. The Manor Surgery
**South East Oxfordshire:**
The South East Locality is made up of 10 GP practices which cover the registered population. The GP Locality Clinical Director is Dr Ed Capo-Bianco. The role of Deputy Locality Clinical Director is currently vacant. The 10 member practices in the South East Locality are:

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

**South West Oxfordshire:**
The South West Locality is made up of 12 GP practices covering the population. The GP Locality Clinical Director and Deputy Locality Clinical Director positions are both vacant. The 12 member practices in the South West Locality are:

1. Abingdon Surgery
2. Berinsfield Health Centre
3. Clifton Hampden Surgery
4. Church Street Practice
5. Didcot Health Centre
6. Long Furlong Surgery
7. Marcham Road Surgery
8. Malthouse Surgery
9. Newbury Street Practice
10. Oak Tree Health Centre
11. White Horse Surgery
12. Woodlands Medical Centre
**West Oxfordshire**: The West Oxfordshire Locality is made up of 8 GP practices covering the registered population. The GP Locality Clinical Director was Dr Miles Carter until 31 March 2020. The Deputy Locality Clinical Director is Dr Amar Latif. The 8 member practices that make up the West Locality are:

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

**Members of the Board**

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

- Dr Kiren Collison, Clinical Chair
- Louise Patten, Chief Executive (until 31 March 2020)

The Board of OCCG comprises GP representatives, lay members, executive directors and a representative from Public Health, Adult Social Care and an external Medical Specialist. Individual profiles are available on OCCG’s website [here](#). The composition of the Board as at 31 March 2020 includes:

- Ansaf Azhar, Corporate Director of Public Health and Wellbeing, Oxfordshire County Council
- Dr Ed Capo-Bianco, South East Locality Clinical Director
- Dr Miles Carter, West Locality Clinical Director
- Dr David Chapman, Oxford City Clinical Director
- Jo Cogswell, Director of Transformation
- Dr Kiren Collison, Clinical Chair
- Heidi Devenish, Practice Manager Representative
- Roger Dickinson, Lay Member Lead for Governance and Vice Chair

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3 Dr Miles Carter resigned on 31 March 2020.
Dr Shelley Hayles, North Locality Clinical Director
Diane Hedges, Chief Operating Officer and Deputy Chief Executive
Gareth Kenworth, Director of Finance
Catherine Mountford, Director of Governance
Dr Will O’Gorman, North East Locality Clinical Director
Louise Patten, Chief Executive
Dr Guy Rooney, Medical Specialist Advisor
Duncan Smith, Lay Member for Finance
Stephen Chandler, Corporate Director Adults and Housing Services, Oxfordshire County Council
Professor Louise Wallace, Lay Member for Public Participation and Involvement (PPI)
Sula Wiltshire, Director of Quality and OCCG Lead Nurse

**Statement of Disclosure to Auditors**

Each individual who is a member of the Board at 31 March 2020 confirms:

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

Please see the Annual Governance Statement on page 28 for information about the committees of the Board including membership and attendance.

The Board member Register of Interests is available on the CGGs website [here](#).

**Personal Data Related Incidents**

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

**Modern Slavery Act**

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

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). Louise Patten was the Accountable Officer of OCG until 31 March 2020. NHS England appointed Fiona Wise to be the Interim Accountable Officer of Oxfordshire Clinical Commissioning Group as of 1 April 2020 until Dr James Kent was appointed on 18 May.

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

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

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

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

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
• Prepare the accounts on a going concern basis; and
• Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that Ernst & Young LLP auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Disclosures:

•

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.

Dr James Kent
Accountable Officer
25 June 2020
**Governance Statement**

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

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

As at 1 April 2020, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

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

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

**Governance arrangements and effectiveness**
The main function of the Governing Body (Board) is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.
The responsibilities of the Board are detailed in the NHS Oxfordshire Clinical Commissioning Group Constitution. Supporting documents to the Constitution include the Scheme of Delegation, Standing Orders and responsibilities of the members of the Board.

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

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

The Practice Members are represented on the Board through the six Locality Clinical Directors who are appointed in line with Standing Orders.

In accordance with its Constitution, the Board held five meetings in public in this period (the meeting due to be held in March was cancelled due to the need to concentrate on response to COVID-19). All meetings were quorate in terms of executive and lay member representation. A table of attendance is included in Appendix 1 on page 58.

The 2019/2020 Board agenda has focused on organisational objectives, national priorities and the local health economy’s priorities in the Operational Plan. The Board has also held workshops on strategic and corporate objectives.

Standing agenda items include The Chief Executives Report, Locality Clinical Director Reports, Integrated Performance Report, Finance Report, Corporate Governance Report, Strategic Risk Register and Board Committee Reports. In addition to the standing agenda items the Board agenda in 2019/2020 has included reporting on:

- Operational Plan
- Oxfordshire Safeguarding Adult and Children’s Annual Reports
- Long Term Plan Five Year Strategy
Board Committees

All committees outlined below produce an annual report that is presented to the Board and in addition some of them undertake self-assessments of effectiveness that informs the report.

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 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 a lay member (a qualified accountant), and a 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 1 on page 58. The Audit Committee met five times during 2019/2020.

The following internal audits have been received:

- Collaborative Working
- Conflicts of Interest
- Risk Management and Assurance
Saving Plan Delivery
Data Security and Protection Toolkit (including GDPR Actions)
Data Security and Protection Toolkit (including post GDPR Actions)
Continuing Healthcare
Clinical Quality Governance
Incident Management and Cyber Security Follow Up

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 2020/2021. An Annual Report of its activity was made to the Board.

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

The Committee comprises at least five Board members: two Lay Board members (including at least one qualified accountant), one Locality Clinical Director, the Director of Finance and Chief Operating Officer/Deputy Chief Executive. The Lay Member (Finance) undertakes the role of Chair. Other members of OCCG management and external advisors may be invited to attend where appropriate. A table of attendance is included in Appendix 1 on page 58.

The Finance Committee met seven times during 2019/2020. In addition to standing agenda items reporting on progress on business cases and financial risk, the Committee received reports and updates including:

- Section 75 Performance – Dashboard Review
- Estates Bids and Outline Business Cases
- Continuing Healthcare Authorisation Policy and Equity and Choice Policy
- Prescribing Incentive Scheme
- Approach to Care Home Contracts 2020/2021
- Report on Findings from the Clinical Audit to Prevent Admission to Hospital
- Update on New Equipment Provider
- Proposal for Decision and Metrics to Demonstrate Value for Money
- Home Assessment Reablement Team Cost of Services
- Annual Report
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 its annual report to the Board.

**Quality Committee**

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

The Quality Committee is Chaired by the lay member with responsibility for patient and public involvement. Members are the Director of Quality, a locality clinical director, Specialist Medical Adviser, Chief Operating Officer/Deputy Chief Executive and the Director of Governance. Non-voting ex-officio attendees of the committee comprise the Clinical Director of Quality, 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 1 page 58.

The Quality Committee met four times during 2019/2020 and in addition to standing items on quality and performance reports, risk register, patient experience, clinical effectiveness, safeguarding, inspections and reviews the Committee has received reports and updates on:

- Immunisations
- Child Death Overview Panel
- Vulnerable Adult Mortality Annual Report
- Special Educational Needs and Disability Annual Report
- Gosport Mortality Review
- Vulnerable Adult Mortality Annual Report
- Suicide Prevention Strategy
- Infection Prevention and Control Report and Plan
- Annual Medicines Optimisation Report
- Serious Incidents Report
- Midwifery Led Units including the Horton
- Enhanced Multi-Disciplinary Team Proposal
- Safeguarding - Mental Capacity Act
- Proposal for Oversight of Quality for Challenged Constitutional Areas
• The minutes of the Quality Committee are made available to the public with Board papers.
• An Annual Report of its activity was made to the Board.

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

The Remuneration Committee was Chaired by the Lay Vice Chair of the Board until November 2019 and then by the Lay Member (Finance) with the Chair and other lay members making up the membership. The Accountable Officer and Human Resources lead and other external experts are asked to support the Committee as required.

The Remuneration Committee met once during 2019/2020 and fulfilled its remit and responsibilities focusing on:

• Executive Director Remuneration
• Oxfordshire Integrated Care Partnership Managing Director

A table of attendance for the meeting is included at Appendix 1 on page 58.

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

The Committee met four times during 2019/2020. As well as standing agenda items on finance, quality, Head of Primary Care update and risk register the Committee has received the following:

• Primary Care Schemes
• Prescribing Incentive Scheme
• Primary Care Networks
• Annual Report
• Recommissioning Specialist Homeless Primary Care Service
• Review of Locally Commissioned Services
• GP Appointments
• Enabling Primary Care Through Digital Transformation
• Primary Care Estates
• Delegated Commissioning Internal Audit

All meeting papers and minutes are published on the OCCG website and an Annual Report of activity is made to the Board.

CCG Executive Committee

The role of the Committee is to make recommendations to the CCG Board on strategy and commissioning plans and take day to day decisions on performance management and risk management to provide robust assurance to the CCG Board.

The Committee supports the CEO to ensure the CCG fulfils its duties to exercise its functions effectively and monitor and manage delivery of the CCG plan, maintain an oversight of performance and financial position, provide assurance on the management of procurement processes and ensures the CCG has access to the capacity and capability it needs to deliver its functions. Standing items at every meeting are: corporate business – reports from other committees, review of new risks, Programme Board highlight reports, Locality Transformation Highlight reports, strategy setting, corporate risk register.

The Committee is chaired by the Chief Executive Officer and members are Clinical Chair, six Locality Clinical Directors, Chief Operating Officer/Deputy Chief Executive, Director of Finance, Director of Quality, Director of Governance and Director of Transformation. Quorum is at least seven members, four GPs and two other Directors either the Chief Executive or Chief Operating Officer/Deputy Chief Executive.

The committee has met 10 times (the meeting due to be held in March was cancelled due to the need to concentrate on response to COVID-19) and in addition to standing items the Committee has received the following:

• GP Workload in the Community
• Primary Care Networks
• Barton Healthy New Town
• Primary Care Services and Strategy
• Long Term Plan
• Horton Hospital Maternity Services
• Continuing Healthcare
• Integrated Care Partnership
• Buckinghamshire, Oxfordshire and Berkshire West Commissioning Architecture
• Gender Diversity in Medical Leadership

A table of attendance is included in Appendix 1 on page 58.

**UK Corporate Governance Code**

OCCG is 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 2020 and up to the signing of the statement, we complied with the provisions set out in the Code and applied the principles of the Code.

**Discharge of Statutory Functions**

In light of the 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, the accountable officer, can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

**Risk management arrangements and effectiveness**

The Audit Committee reviews the full Strategic Risk Register at every meeting; the Quality Committee reviews and discusses risks relating to quality and performance; the Finance Committee reviews and discusses financial risks; the Oxfordshire Primary Care Commissioning Committee reviews and discusses Primary Care risks and the CCG Executive Committee reviews and discusses the strategic risks bi-monthly.

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

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

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

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

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

Project risks are managed through the Project Management Office using the Verto data system.

**Other sources of assurance**

*Internal Control Framework*

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

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

*Annual audit of conflicts of interest management*

The 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.
OCCG’s internal auditors carried out the annual audit of conflicts of interest with an overall assessment of ‘reasonable assurance’. The following were the key findings from the audit:

- Processes around the logging of annual declaration returns to be tightened
- Ensuring Board and Committee members complete mandatory training
- Ensuring actions to be taken when a potential conflict arises in a meeting are recorded
- Processes around updating Registers of Interest to be tightened

Action has been taken to address all these recommendations.

Data Quality

The sourcing of data and management of provider data quality is achieved via contracts. The data contract management processes are well established in Oxfordshire and we continue to capitalize on strong relationships between Commissioning Support Unit, OCCG and providers’ information teams to drive improvement.

There are two main ways in which data quality is improved:

- Through data quality check routines and data quality improvement targets or programmes
- Through consuming the data and feeding the results back to those whose work it represents.

Developments in 2018/19 around the automation of data loading processes into a single data warehouse will increase the data quality requirements for providers as insufficient quality will simply prevent data submission. The automation of key data processing processes creates capacity for value adding work.

The nationally mandated dataset for community, and the Mental Health Minimum Dataset has allowed the decommissioning of local datasets and switching to national data sources. As a result we have been able to work on improving data quality for nationally mandated data. This enables us to harness national processes for improvement as well as provide us with data that is comparable across providers.

Most effective to driving data quality improvement is the use of the data and deriving value from using the data as close to the point of capture as possible. When data is experienced as an asset and is valued, its quality sustainably improves.

The move to population health management approaches leads to a different data consumption which will help drive quality improvements. Increasingly cross provider work groups are using the data to understand population segmentation and review how services might be best organised to meet population health needs. There are examples where staff are now focused on data capture in order to ensure they can benefit from the analytics. This cross provider approach is a departure from the traditional data
review within individual contract approaches and is starting to change attitudes.

*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 a data security and protection 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.

OCCG places 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 processes and procedures in line with the data security and protection 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.

Requirements of the data security and protection toolkit include data flow mapping which is the process of capturing all inbound and outbound data that is valuable to an organisation. An information asset register is also produced logging all the information assets that the organisation holds. Both of these inform the Business Continuity Plans for the organisation and are therefore crucial for the organisations functioning.

During 2019/2020 OCCG continued to develop and implement an action plan following the introduction of the General Data Protection Regulation (GDPR) and the new Data Protection Act (DPA) 2018. OCCG has submitted the Data Security and Protection Toolkit. Key developments to ensure compliance with the toolkit included: appointment of a Data Protection Officer (DPO); updating the Privacy Notice on the CCG website; a review of all relevant Policies to ensure they were compliant with the new legislation; embedding Data Protection Impact Assessments (DPIA) within commissioning processes; undertaking a comprehensive Data Flow and Information Assets mapping process and establishing the legal basis under the new legislation.

All 106 mandatory compliance requirements within the Data Security and Protection Toolkit were met and the overall assessment was ‘standard met’ which is the required standard.

*Business Critical Models*

The CCG does not own and has not developed any business critical models that have supported its planning in 2019/2020. Our Commissioning Support Unit partner holds models that may be used on our behalf but these have not been used to date. We are aware of the recommendations for public sector made in the Macpherson Report and will apply them as and when we place reliance on business critical models to support the CCG.
**Control Issues**

As identified in the Month 9 Governance Statement return NHS Constitutional requirements are not being met by providers. Work is focussing on Gynaecology, Ear, Nose and Throat (ENT), Ophthalmology, Outpatients (John Radcliffe and Horton Hospitals), Cardiology and the 26 week initiative. Regular weekly patient Tracking List (PTL) meetings are taking place and the use of digital clinics will improve outpatient efficiency and reduce numbers in clinics. A plan is being developed to increase activity through theatres. All patients who wait over 52 weeks are reviewed to establish whether they came to harm, including psychosocial harm, as a result of their long wait. This work has been further impacted by the pause in routine referrals, in line with national guidance, during the COVID-19 response period. OUH has continued to receive two week wait cancer referrals and all other urgent referrals during this time.

There are a number of initiatives within Oxford University Hospitals NHS Foundation Trust that are expected to improve ambulance handover times. The Diagnostics Programme and Cancer Improvement Plan both have focus on early diagnosis and a project to enable 2 week wait referrals to be made directly from A&E speeding up the patient pathway is underway.

In addition there was is a referral by the Horton Health Overview and Scrutiny Committee under Regulation 23(9)(a) and 23(9)(c) to the Secretary of State (SoS) of the decision by the CCG (in September 2019) to create a single obstetric unit for Oxfordshire for the foreseeable future. The CCG received written confirmation (18 September 2020) from NHS England/Improvement that they were assured the process followed had delivered what had been asked by the Independent Reconfiguration Panel. The High Court of Justice dismissed the appeal (11 April 2019) in the judicial review of the transformation consultation process that took place in early 2017. The original first instance decision made back in December 2017 by Mr Justice Mostyn therefore still stands in OCCG’s favour.

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

The role of the OCCG Board includes, among other things, assurance of decision-making arrangements, financial stewardship of public funds, approving commissioning plans, monitoring performance against plan and ensuring value for money. The Board receives regular reports on financial planning and performance.

Internal Audit undertake a number of audits to ensure the CCG’s internal control processes are operating effectively. The audits undertaken in 2019/20 are detailed under the Audit Committee section (on page 30).

NHS England has a statutory duty to undertake annual assessment of CCGs. This is undertaken using the Improvement and Assessment Framework (IAF), with the overall assessment derived from CCGs’ performance against the IAF indicators, including an assessment of CCG leadership and financial management.

Each CCG receives an overall assessment that places their performance in one of four categories: outstanding, good, requires
improvement, or inadequate. OCCG received an overall rating of good in the last set of published assessments for 2018/19; including a rating of Good for the Quality of Leadership Indicator. The ratings for 2019/20 are not yet confirmed.

NHS England and Improvement assesses the CCG on its compliance with statutory guidance on patient and public participation in commissioning health and care: the CCG Improvement and Assessment Framework (IAF) Patient and Community Engagement Indicator. A robust, and improvement focused, process of national assessment was carried out to reach a final RAGG rating. The final RAGG rating for OCCG was GREEN.

Delegation of Functions

The delegation of CCG functions is defined in the Scheme of Delegation. Where roles and responsibilities are delegated to Committees, feedback is provided to the Board through the approved committee minutes which are presented to every Board meeting and by the Committee Chair directly to the Chief Executive.

Through the joint working as part of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) the three CCGs have committed, where appropriate, to undertake commissioning decisions at scale. This will need to be supported by appropriate governance arrangements such as the development of a joint committee to enable joint decision making. The CCGs have agreed this approach and the work is currently being taken forward. As part of this the three CCGs are setting up a Joint Commissioning Committee and have agreed to the appointment of a single Accountable Officer/ICS Lead and a single management team.

Counter fraud arrangements

Counter Fraud support is provided to the CCG by RSM UK Tax and Accounting Ltd. Representatives from RSM attend the OCCG Audit Committee meetings and present reports and updates in respect of counter fraud work undertaken on the various standards. Audits are undertaken throughout the year and the results presented to the Audit Committee. Any risks identified as a result of these audits are assigned an owner and a work plan is implemented to address. The Director of Finance is the Executive Board member with responsibility for fraud, bribery and corruption. The Director of Finance approves the annual work plan and liaises with the Local Counter Fraud Specialist in relation to progress against the plan, referrals and other counter fraud issues. The NHS Counter Fraud Authority (NHSCFA) standards support commissioners in implementing appropriate measures to tackle fraud, bribery and corruption. The work plan includes priority areas and not all the tasks detailed in the standards will necessarily be covered in the work plan in any one year. Finance, internal and external audit, risk, communications and human resources, amongst others, are involved in helping the CCG meet the standards. The CCG completes the Self Review Tool (SRT) summarising the counter fraud work the CCG has conducted over the previous financial year. In 2018/19 the SRT resulted in an overall rating of green. The green rating assesses the CCG as fully compliant with the standards. For 2019/20 the CCG anticipates retaining the overall rating of green.
Head of Internal Audit Opinion

In accordance with the Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation’s risk management, control and governance processes. The opinion contributes to the organisation’s annual governance statement. For the 12 months ended 30 March 2020, the head of internal audit opinion for Oxfordshire CCG is as follows:

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

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

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

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

Conclusion

No significant internal control issues have been identified.

Dr James Kent
Accountable Officer, 25 June 2020
Remuneration and Staff Report

Remuneration Committee

Each clinical commissioning group has a Remuneration Committee; the role of the committee is to advise on appropriate remuneration levels and terms of service for the Executive Team and Clinical Leads. Details of membership and terms of reference of the Remuneration Committee are available on page 33.

Policy on the remuneration of senior managers

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

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

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

Policy on the remuneration of very senior managers

All very senior manager remuneration (VSM) is determined by OCCG’s Remuneration Committee based on available national guidance, benchmarking data against other CCGs and with due regard for national pay negotiations/awards for NHS staff on national terms and conditions. The Remuneration Committee is also cognisant of public sector pay restraint and its responsibility to ensure that executive pay remains publicly justifiable. The Remuneration Committee acknowledges and commits to complying with the requirement to seek pre-approval from NHS England for salaries in excess of £142,500.
Senior Manager Remuneration (including salary and pension entitlements) 2019/20

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Oxfordshire CCG Salary &amp; Fees (Bands of £5000)</th>
<th>Taxable benefit (rounded to nearest £100)</th>
<th>Annual Performance RelatedBonuses (Bands of £5000)</th>
<th>Long Term Performance Related Bonuses (Bands of £5000)</th>
<th>All Pension Related Benefits (Bands of £2500)</th>
<th>TOTAL Oxfordshire CCG (Bands of £5000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ed Capo-Bianco</td>
<td>South East Locality Clinical Director</td>
<td>£60-65</td>
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<td>15-17.5</td>
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<tr>
<td>Miles Carter</td>
<td>West Locality Clinical Director</td>
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</tr>
<tr>
<td>David Chapman</td>
<td>Oxford City Locality Clinical Director</td>
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<td>Clinical Chair</td>
<td>£90-95</td>
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<td>17-19.5</td>
<td>110-115</td>
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<tr>
<td>Jonathan Crawshaw</td>
<td>Locality Clinical Director</td>
<td>£35-40</td>
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<td>17-19.5</td>
<td>50-55</td>
</tr>
<tr>
<td>Joanne Cogswell</td>
<td>Director of Transformation</td>
<td>£100-105</td>
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<td>130-132.5</td>
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<tr>
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<tr>
<td>Shelley Hayles</td>
<td>North Locality Clinical Director</td>
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</tr>
<tr>
<td>Diane Hedges</td>
<td>Chief Operating Officer and Deputy Chief Executive</td>
<td>£115-120</td>
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<td>0</td>
<td>120-122.5</td>
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<tr>
<td>Gareth Kenworthy - see note below</td>
<td>Director of Finance</td>
<td>£115-120</td>
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<tr>
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<td>£105-110</td>
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<td>3-5.5</td>
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</tr>
<tr>
<td>Will O’Gorman</td>
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<tr>
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<tr>
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<td>£15-20</td>
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<tr>
<td>Duncan Smith</td>
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<td>£15-20</td>
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<td>15-20</td>
</tr>
<tr>
<td>Louise Wallace</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>15-20</td>
</tr>
</tbody>
</table>

Notes:
- Louise Patten is seconded from Buckinghamshire CCG so that the remuneration for 2019/20 shown above is a proportion of her total salary.
- The CCG receives a contribution towards the costs of Gareth Kenworthy for his role within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS).
# Senior Manager Remuneration (including salary and pension entitlements) 2018/19

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Oxfordshire CCG Salary &amp; Fees (Bands of £5000)</th>
<th>Taxable benefits (rounded to nearest £100) £00</th>
<th>Annual Performance Related Bonuses (Bands of £5000) £00</th>
<th>Long Term Performance Related Bonuses (Bands of £5000) £00</th>
<th>All Pension Related Benefits (Bands of £5000) £00</th>
<th>TOTAL Oxfordshire CCG (Bands of £5000) £00</th>
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<tr>
<td>Stephen Attwood</td>
<td>Locality Clinical Director</td>
<td>45-50</td>
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<tr>
<td>Ed Capo-Bianco</td>
<td>Locality Clinical Director</td>
<td>60-65</td>
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<td>0</td>
<td>0</td>
<td>10-12.5</td>
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</tr>
<tr>
<td>Miles Carter</td>
<td>Locality Clinical Director</td>
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<td>0</td>
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<tr>
<td>David Chapman</td>
<td>Locality Clinical Director</td>
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<tr>
<td>Kiren Collison</td>
<td>Clinical Chair</td>
<td>90-95</td>
<td>0</td>
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<td>17.5-20</td>
<td>110-115</td>
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<tr>
<td>Jonathan Crawshaw</td>
<td>Locality Clinical Director</td>
<td>60-65</td>
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<tr>
<td>Shelley Hayles</td>
<td>Locality Clinical Director</td>
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<td>Chief Operating Officer and Deputy Chief Executive</td>
<td>115-120</td>
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<tr>
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<td>Locality Clinical Director</td>
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<td>0-2.5</td>
<td>10-15</td>
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<tr>
<td>Paul Park</td>
<td>Locality Clinical Director</td>
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<tr>
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<td>Chief Executive</td>
<td>105-110</td>
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<tr>
<td>Guy Rooney</td>
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<tr>
<td>Ursula Wiltshire</td>
<td>Director of Quality and Innovation</td>
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<tr>
<td>Duncan Smith</td>
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<tr>
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<td>15-20</td>
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<td>0</td>
<td>0</td>
<td>15-20</td>
</tr>
</tbody>
</table>

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- The CCG receives a contribution towards the costs of Gareth Kenworthy for his role within the BOB STP.
# Pension Benefits as at 31 March 2020

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Notes</th>
<th>Real increase in pension at pension age (bands of £2,500)</th>
<th>Real increase in pension lump sum at pension age (bands of £2,500)</th>
<th>Total accrued pension at pension age at 31 March 2019 (bands of £5,000)</th>
<th>Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value at 1st April 2018</th>
<th>Real increase in Cash Equivalent Transfer Value</th>
<th>Cash Equivalent Transfer Value at 31 March 2019</th>
<th>Employer’s contribution to stakeholder pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ed Capo-Bianco</td>
<td>South East Locality Clinical Director</td>
<td></td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>10-15</td>
<td>15-20</td>
<td>112</td>
<td>11</td>
<td>126</td>
<td>0</td>
</tr>
<tr>
<td>Miles Carter</td>
<td>West Locality Clinical Director</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>David Chapman</td>
<td>Oxford City Locality Clinical Director</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>791</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Kiren Collison</td>
<td>Clinical Chair</td>
<td></td>
<td>0-2.5</td>
<td>0</td>
<td>15-20</td>
<td>25-30</td>
<td>207</td>
<td>18</td>
<td>229</td>
<td>0</td>
</tr>
<tr>
<td>Jonathan Crawshaw</td>
<td>Locality Clinical Director</td>
<td></td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>15-20</td>
<td>15-20</td>
<td>151</td>
<td>8</td>
<td>169</td>
<td>0</td>
</tr>
<tr>
<td>Joanne Cogswell</td>
<td>Director of Transformation</td>
<td></td>
<td>0-2.5</td>
<td>0-10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>76</td>
<td>82</td>
</tr>
<tr>
<td>Heidi Deverish</td>
<td>Practice Manager Representative</td>
<td></td>
<td>0-2.5</td>
<td>0</td>
<td>0-5</td>
<td>0</td>
<td>35</td>
<td>3</td>
<td>39</td>
<td>0</td>
</tr>
<tr>
<td>Diane Hodges</td>
<td>Chief Operating Officer and Deputy Chief Executive</td>
<td></td>
<td>5-7.5</td>
<td>10-12.5</td>
<td>30-35</td>
<td>65-70</td>
<td>622</td>
<td>48</td>
<td>684</td>
<td>0</td>
</tr>
<tr>
<td>Gareth Kenworthy - see note below</td>
<td>Director of Finance</td>
<td></td>
<td>2.5-5</td>
<td>2.5-5</td>
<td>35-40</td>
<td>75-80</td>
<td>536</td>
<td>64</td>
<td>613</td>
<td>0</td>
</tr>
<tr>
<td>Catherine Mountford</td>
<td>Director of Governance</td>
<td></td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>40-45</td>
<td>120-125</td>
<td>882</td>
<td>40</td>
<td>943</td>
<td>0</td>
</tr>
<tr>
<td>Will O’Gorman</td>
<td>Locality Clinical Director</td>
<td></td>
<td>2.5-5</td>
<td>7.5-10</td>
<td>15-20</td>
<td>40-45</td>
<td>201</td>
<td>74</td>
<td>280</td>
<td>0</td>
</tr>
<tr>
<td>Louise Patten</td>
<td>Chief Executive</td>
<td></td>
<td>2.5-5</td>
<td>0</td>
<td>35-40</td>
<td>45-50</td>
<td>601</td>
<td>57</td>
<td>672</td>
<td>0</td>
</tr>
<tr>
<td>Ursula Wiltshire</td>
<td>Director of Quality and Innovation</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Notes:
- Louise Patten - seconded from Buckinghamshire Clinical Commissioning Group
- Lay members and the Specialist Medical Advisor do not receive pensionable remuneration.
- The calculations above do not take account of the McCloud ruling (This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the eldest members who retained a Final Salary design). We believe this to be appropriate given the considerable uncertainty on the implications of any future ruling in this matter

## 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 2019

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Notes</th>
<th>Real increase in pension at pension age (bands of £2,500) £'000</th>
<th>Real increase in pension lump sum at pension age (bands of £2,500) £'000</th>
<th>Total accrued pension at pension age at 31 March 2019 (bands of £5,000) £'000</th>
<th>Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000) £'000</th>
<th>Cash Equivalent Transfer Value at 1st April 2018 £'000</th>
<th>Real increase in Cash Equivalent Transfer Value £'000</th>
<th>Cash Equivalent Transfer Value at 31 March 2019 £'000</th>
<th>Employer’s contribution to stakeholder pension £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stephen Attwood</td>
<td>Locality Clinical Director</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ed Capo-Bianco *</td>
<td>Locality Clinical Director</td>
<td></td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>5-10</td>
<td>10-15</td>
<td>86</td>
<td>24</td>
<td>112</td>
<td>0</td>
</tr>
<tr>
<td>Miles Carter</td>
<td>Locality Clinical Director</td>
<td></td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>0-5</td>
<td>0-9</td>
<td>164</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>David Chapman</td>
<td>Locality Clinical Director</td>
<td></td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>40-45</td>
<td>65-90</td>
<td>190</td>
<td>70</td>
<td>761</td>
<td>0</td>
</tr>
<tr>
<td>Kiren Collison *</td>
<td>Clinical Chair</td>
<td></td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>15-20</td>
<td>25-30</td>
<td>163</td>
<td>38</td>
<td>207</td>
<td>0</td>
</tr>
<tr>
<td>Jonathan Crawshaw *</td>
<td>Locality Clinical Director</td>
<td></td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>10-15</td>
<td>10-15</td>
<td>117</td>
<td>31</td>
<td>161</td>
<td>0</td>
</tr>
<tr>
<td>Heidi Devenish</td>
<td>Practice Manager Representative</td>
<td></td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>2-5-5</td>
<td>0-2-5</td>
<td>21</td>
<td>13</td>
<td>35</td>
<td>0</td>
</tr>
<tr>
<td>Diane Hedges</td>
<td>Chief Operating Officer and Deputy Chief Executive</td>
<td></td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>25-30</td>
<td>50-55</td>
<td>519</td>
<td>87</td>
<td>622</td>
<td>0</td>
</tr>
<tr>
<td>Gareth Kenworrthy</td>
<td>Director of Finance</td>
<td></td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>30-35</td>
<td>70-75</td>
<td>443</td>
<td>80</td>
<td>536</td>
<td>0</td>
</tr>
<tr>
<td>Catherine Mountford</td>
<td>Director of Governance</td>
<td></td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>35-40</td>
<td>115-120</td>
<td>775</td>
<td>84</td>
<td>862</td>
<td>0</td>
</tr>
<tr>
<td>Will O’Gorman</td>
<td>Locality Clinical Director</td>
<td></td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>10-15</td>
<td>30-35</td>
<td>171</td>
<td>6</td>
<td>251</td>
<td>0</td>
</tr>
<tr>
<td>Paul Park *</td>
<td>Locality Clinical Director</td>
<td></td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>20-25</td>
<td>50-55</td>
<td>182</td>
<td>7</td>
<td>354</td>
<td>0</td>
</tr>
<tr>
<td>Louise Patten</td>
<td>Chief Executive</td>
<td></td>
<td>7.5-10</td>
<td>10-12.5</td>
<td>30-35</td>
<td>45-90</td>
<td>475</td>
<td>108</td>
<td>601</td>
<td>0</td>
</tr>
<tr>
<td>Ursula Wiltshire</td>
<td>Director of Quality and Innovation</td>
<td></td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>0-5</td>
<td>0-5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Note:
- Louise Patten - seconded from NHS Buckinghamshire Clinical Commissioning Group
- Lay members and the Specialist Medical Advisor do not receive pensionable remuneration.
- The calculations above do not take account of the recent McCloud ruling (This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the eldest members who retained a Final Salary design). We believe this to be appropriate given the considerable uncertainty on the implications of any future ruling in this matter.

## 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 2019/20 was £155-£160k (2018/19 was £155k to £160k) on an annualised basis. This was 3.1 times (2018/19 3.2 times) the median remuneration of the workforce, which was £51,378 (2018/19 £47,798).

In 2019-20, 1 employee (2018-19 1 employee) received remuneration in excess of the highest paid director/member of the OCCG Board. Remuneration ranged from £15,000 to £182,000 (2018-19 £3,000 to £180,000).

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

**Staff Report**

**Staff sickness absence**

Below outlines OCCG’s sickness absence data from 1 April 2019 to 31 March 2019. For information about sickness absence data for 2019/20 please go [here](#).

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days Lost</td>
<td>594</td>
<td>753</td>
</tr>
<tr>
<td>Average full time equivalent</td>
<td>94.5</td>
<td>90</td>
</tr>
<tr>
<td>Average working Days Lost</td>
<td>6.3</td>
<td>8.4</td>
</tr>
</tbody>
</table>

Sickness absence is managed in a supportive and effective manner by OCCG managers, with professional advice and targeted support from human resources (HR), occupational health, employee assistance programme and staff support services which are appropriate and responsive to the needs of our workforce. OCCG’s approach to managing sickness absence is governed by a clear HR policy and this is further supported by the provision of HR advice and training sessions for all line managers on the effective management of sickness absence.
Managers ensure that the culture of sickness reporting is embedded within their teams and sickness absence is actively monitored and formally reported to OCCG on a quarterly basis as part of the workforce reporting process.

OCCG proactively promotes the health and wellbeing of staff in line with its Health and Wellbeing Policy. The policy is implemented by an active staff led Health and Wellbeing Group who organise events throughout the year with a large number of staff participating. Events have included fund raising activities, annual sporting challenge and events aimed to support employees wellbeing. During January 2020 a new initiative, the 'Daily Mile' was introduced which sees a group of staff walking a mile every day at lunchtime. The walk has a team leader and staff benefit from time out of the office to support their physical, emotional, social and mental health.

**Staff numbers and gender analysis**

OCCG has a workforce comprised of employees from a wide variety of professional groups. At the end of 2019/20 OCCG employed 118 staff (headcount), of which 88 were women and 30 men. As of 31 March 2020, the Board of OCCG was made up of 7 women and 4 men. Below is a breakdown of gender analysis. The membership body of OCCG is made up of all 68 (as at 31 March 2020) GP practices within Oxfordshire; a breakdown of membership by gender is not available.

Below outlines the gender breakdown of staff:

<table>
<thead>
<tr>
<th></th>
<th>Female Headcount</th>
<th>Male Headcount</th>
<th>Total Headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEO and Board</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Very Senior Managers including GPs</td>
<td>9</td>
<td>14</td>
<td>23</td>
</tr>
<tr>
<td>All other Employees</td>
<td>72</td>
<td>12</td>
<td>71</td>
</tr>
<tr>
<td>Total Employees</td>
<td>88</td>
<td>30</td>
<td>118</td>
</tr>
</tbody>
</table>

The below table shows average number of people (headcount) employed by OCCG, which equated to an average 86 whole time equivalent staff.
<table>
<thead>
<tr>
<th></th>
<th>2019/20 Permanently employed Number</th>
<th>Other Numbers</th>
<th>2019/20 Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>94</td>
<td>25.75</td>
<td>115.5</td>
</tr>
<tr>
<td>Of the above:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of whole time equivalent</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(WTE) people engaged on capital projects</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Trade union official facility time**

OCCG has one trade union representative who worked 64.25 facility hours during 2019/20 at a cost of £1,210.

<table>
<thead>
<tr>
<th>Number of employees who were relevant union officials during the relevant period</th>
<th>Full-time equivalent employee number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.6WTE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of time</th>
<th>Number of employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>1-50%</td>
<td>1</td>
</tr>
<tr>
<td>51%-99%</td>
<td>0</td>
</tr>
<tr>
<td>100%</td>
<td>0</td>
</tr>
</tbody>
</table>

**Percentage of pay bill spent on facility time**

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

Expenditure on consultancy
Expenditure on consultancy was £171k in 2019/20 (£250k in 2018/19) as per Note 5 to the Accounts page XX.

Off Payroll Engagements

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

As at 31 March 2020 there were no off payroll engagements for more than £245 per day that lasted longer than six months.

ii. The CCG did not any new off payroll engagements, or any that reached six months in duration, which cost more than £245 per day, between 1 April 2019 and 31 March 2020.

iii. For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2019 and 31 March 2020.

<table>
<thead>
<tr>
<th>Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total no. of individuals on payroll and off-payroll who have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements. (2)</td>
<td>6</td>
</tr>
</tbody>
</table>

There were no non-contractual severance payments made following judicial mediation, and no payments relating to non-contractual payments in lieu of notice.
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 2019/20**

There were no exit packages in the year 2019/20 and consequently no associated payments.

**Analysis of Other Agreed Departures**

There were no departures made in the year 2019/20 or the previous year 2018/19 in respect of voluntary redundancy, ill health retirements, mutually agreed resignations, early retirements in the efficiency of the service, payments in lieu of notice, exit payments following employment tribunals or court orders or non-contractual payments requiring HMT approval.

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

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

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

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

The Remuneration Report would include the disclosure of exit payments payable to individuals named in that Report. There were none during 2019/20.

**Staff Policies**

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

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

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

OCCG with 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 / training sessions

The results of the staff survey were assessed by the SPF, themes identified and an action plan developed by staff to address different aspects of the feedback. This has resulted in the development of a more agile working approach and focus on OCCG values.

Managers hold regular one-to-one meetings with staff and use the values based appraisal system ensuring all staff work towards clearly defined personal objectives and standards of behaviour. These are supported with learning, training and development opportunities detailed in individual Personal Development Plans.

**Disability information**

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

OCCG is committed to implementing the Workforce Race Equality Standards (WRES) and will work with those organisations it commissions services from and partners to ensure employees from black and ethnic minority backgrounds have equal access to career opportunities and receive fair treatment in the workplace. OCCG has worked with these organisations around the
implementation of the Workforce Disability Equality Standards which was introduced during 2019. The 2019 WRES return is available on the CCGs website here.

Equality and Diversity

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

Health and safety

OCCG recognises that the maintenance of a safe work place and safe working environment is critical to our continued success and accordingly, we view our responsibilities for health, safety and welfare with the utmost 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. Health and Safety training forms part of the suite of statutory and mandatory training which is undertaken by all employees.

Whistleblowing

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

Auditable elements

Please note that the elements of this remuneration and staff report that have been subject to audit are the analysis of staff numbers and gender analysis and related narrative notes on pages 49, the tables of salaries and allowances of senior managers and related narrative notes on page 43 and 44, pension benefits of senior managers and related narrative on pages 45 and 47, exit packages and related narrative on pages 51 and the pay multiples and related narrative notes on page 47.

Dr James Kent
Accountable Officer
25 June 2020
Parliamentary Accountability and Audit Report

Oxfordshire Clinical Commissioning Group is not required to produce a Parliamentary Accountability and Audit Report but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report. For 2019/2020 there is nothing to disclose.

Dr James Kent
Accountable Officer
25 June 2020
Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**PINCER risk stratification tool:** This is a tool that has been developed to identify at-risk patients so that corrective action can be taken to reduce clinically important medication errors in primary care.

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

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

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

**Social prescribing:** This process enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services.
## Appendix 1: Table of Attendance for Board and Committee Meetings

(Membership in line with Constitution dated 14 January 2016)

### OCCG Board (Governing Body)

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