NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Annual Report 2021/22

Clinical Chair's Foreword

It has been another extraordinary year for the Oxfordshire Clinical Commissioning Group (OCCG) and the broader health and social care system in Oxfordshire. In the face of COVID-19 we have seen the successful launch of several vaccines against COVID-19 and a remarkable programme of vaccinations and boosters being delivered across Oxfordshire led by GPs and Primary Care Networks as well as community pharmacists and our own mass vaccination centre in Oxford Kassam stadium run by Oxford Health. The hard work of the primary care teams supported by volunteers from all walks of life has been truly remarkable developing a great spirit of support and cooperation. We also had tremendous efforts from our communities, with council colleagues alongside community workers engaging more vulnerable groups to support them getting appropriate protection against COVID-19.

After this huge success, we have managed to move to the next phase of recovery. We are now developing a major programme to deal with waiting lists which have developed over the pandemic, with targets for the next year and plans of how we deal with this backlog. General Practice is now delivering more appointments than were delivered before COVID-19 with almost the same number of face-to-face appointments, mixed with remote consultations in excess of anything which has been delivered before. This represents a change to how care is being delivered across all systems in different, more efficient ways which allows those at most need to access the appropriate care they require.

Recovery of elective care at our hospitals is progressing with all specialties at the Oxford University Hospitals NHS Foundation Trust now open to referrals following some temporary closures. Our mental health services are facing significant pressures as a result of the pandemic and its effects especially on children and young people. However, you will see later in this report how we are tackling this with the introduction of specialist mental health practitioners across the county this year, working in GP practices to support people with serious mental health illness and the use of new digital apps in the children and adolescent mental health service such as Sleepio, used to treat insomnia in young people, and another app to help manage emotions and reduce self-harm in patients.

The health and social care workforce have continued working tirelessly through this time and despite their fatigue have somehow continued to deliver services. Staff within OCCG have not only continued with their work supporting our providers but have gone out to help support vaccination centres and GP practices to deliver COVID-19 vaccinations. I am grateful to CCG staff, GP practice staff and to those in the wider health and social care system who have worked flexibly to ensure services have continued to support those people living and working in Oxfordshire.

This is my first and likely last foreword for a clinical commissioning group annual report as we move towards a new configuration as an Integrated Care System (ICS) for commissioning and delivering healthcare across Buckinghamshire, Oxfordshire and Berkshire West. This has involved a great deal of planning to move into the new system with many of the OCCG managers and clinicians involved to help build a thriving new organisation. The OCCG has done many good things and won several awards over the past few years. I hope learning from this form of clinically led commissioning will be developed in the new world of the ICS, where integration across systems will be a real focus as well as addressing health inequalities.

My tenure as clinical chair has been short, but I would like to thank all those in the OCCG, providers, voluntary sector workers, local authority and social care staff as well as the people of Oxfordshire who have made my time in the role very fulfilling.

Dr David Chapman, Clinical Chair

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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.'

The following performance report consists of a performance overview and a performance analysis. It outlines what the CCG is; its purpose, statutory duties and how the CCG has executed those duties. It looks at the work of OCCG over the past year, how the organisation has performed and outlines the risks it faces.

Performance Overview

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

OCCG is responsible for commissioning 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 currently commissioned by NHS England (NHSE). Public Health is provided by Oxfordshire County Council (OCC), and includes drug and alcohol, sexual health, health visiting and health promotion services.

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

OCCG is part of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) which covers a population of 1.8 million, three Clinical Commissioning Groups (CCGs) including OCCG, six NHS Trusts, 10 local authorities and 166 GP practices, working together as 45 Primary Care Networks. Integrated care systems aim to bring the NHS together with Local Authorities to further the integration of health and care; improve the health of local populations; transform the quality of care provided and ensure they are sustainable within allocated funding.

The Health and Care Bill 2021 will put Integrated Care Systems on a statutory footing, empowering them to better join up health and care services, improve population health and reduce health inequalities.

Each ICS will be led by an NHS Integrated Care Board (ICB), an organisation with responsibility for NHS functions and budgets, and an Integrated Care Partnership (ICP), a statutory committee bringing together all system partners to produce a health and care strategy. When ICBs are legally established, in July 2022, clinical commissioning groups (CCGs) will be abolished.

It was originally expected that these changes would come in to effect in April 2022. However, this target date has now been changed to 1 July 2022 to allow more time for the remaining parliamentary stages and to enable organisations to manage their more immediate pandemic response priorities. See the NHS 2022/23 priorities and operational planning guidance for more information.

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 OCC and OCCG's Clinical Chair is the vice-chair. The H&WB is a partnership between Local Government, the NHS and the

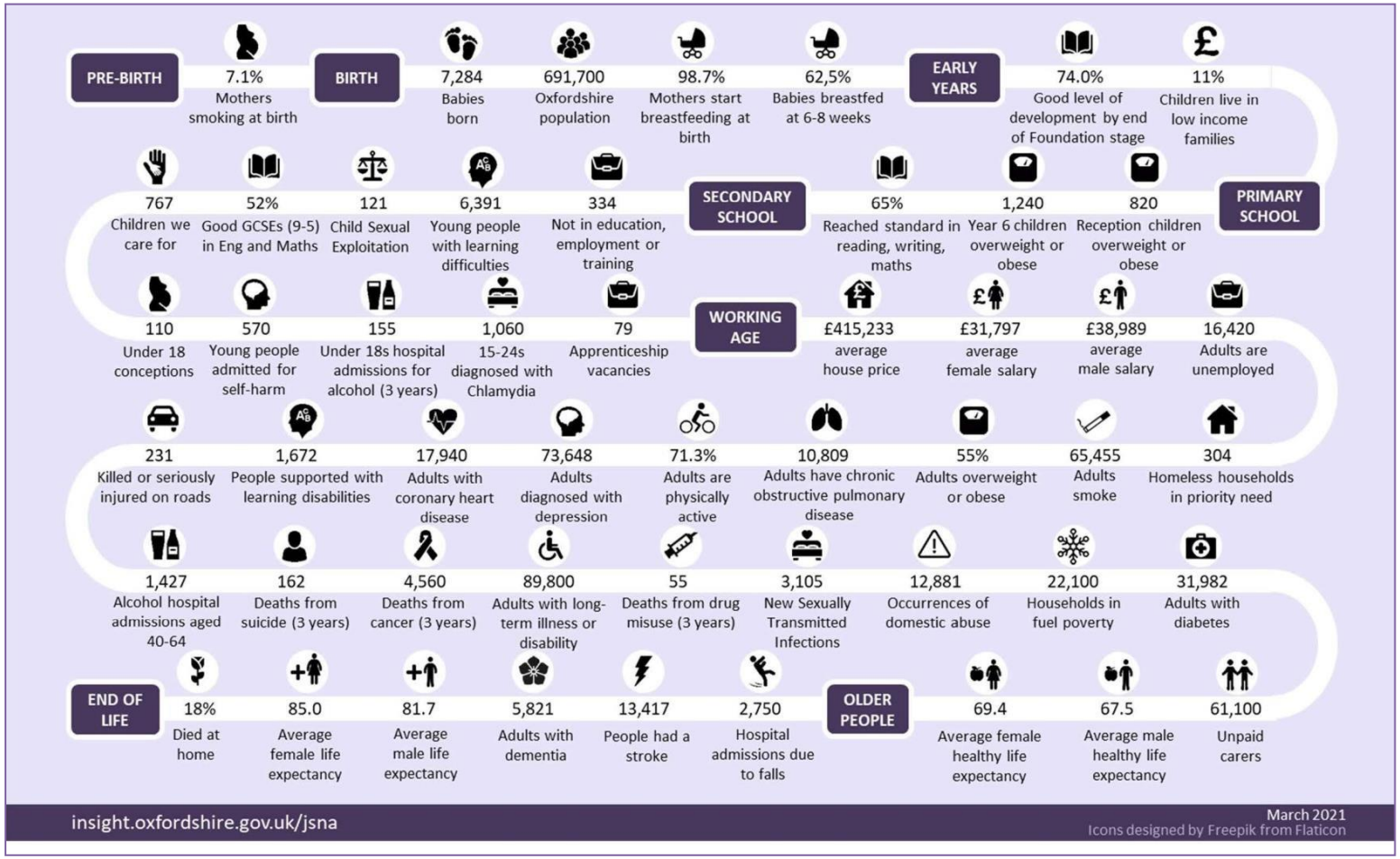
people of Oxfordshire; board members include local GPs, senior Councillors, Healthwatch Oxfordshire and senior officers from the NHS and Local Government.

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

The Oxfordshire Joint Health and Wellbeing Strategy (2018/2023) was developed during 2018. Coordinated by OCC and OCCG the 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 has guided the work of OCCG over the last year alongside our local implementation of the NHS Long Term Plan and operational planning guidance.

Oxfordshire's Population

The information below is from the Joint Strategic Needs Assessment for Oxfordshire 2021 which provides information about the county's population and the factors affecting health, wellbeing, and social care needs. It brings together information from different sources to create a shared evidence base. This informs strategy and supports service planning and decision-making. To read more about the health needs of Oxfordshire's population visit OCC website.[1]



[1] The diagram above is from the Oxfordshire's Joint Strategic Health Needs Assessment 2021 (JSNA), the 2022 JSNA will not be published until October 2022 after the publication of this annual report as such the latest population figure is available on page 4.

Performance Analysis

Overview from Dr James Kent, Accountable Officer

Another extraordinary year in our lives has passed, dominated again by the COVID-19 pandemic.

My condolences to those who have lost loved ones; in the NHS we share in the sadness of those who have suffered a loss, have been seriously ill as a result of the virus or are still suffering from its effects. Many other people have had planned operations and treatments postponed due to the disruption of 'business as usual' services and I share their frustration and disappointment at these delays.

But thanks to the success of the biggest ever vaccination programme in the history of this country, we are now looking towards the future, one in which we can resume a 'new' normal life and work to overcome the difficulties of the last two years.

This year 2021/22 has been remarkable for the success of the vaccination roll-out which has seen 3.7 million jabs delivered across the BOB ICS. Huge thanks go to the thousands of people across the NHS, local authorities and volunteers who contributed to this success.

We began vaccinating our local population in December 2020 – starting with NHS and care staff, residents of care homes, everyone aged over 70 and people who were clinically extremely vulnerable and by 15 February 2021, everyone in these four top priority groups had been offered a vaccine. More than a year later, at the end of March 2022, we were offering vaccinations to all 5 -11 year olds, and a second 'booster' jab to those aged 75.

The uptake of vaccinations across the BOB ICS has been consistently high when compared with other parts of the UK (and among the best in certain groups), but there are certain people in our communities which have been harder to reach and reassure about the benefits of getting jabbed. As of March 2022, 92.7% of the 50+ population has received two vaccinations and 86.2% had received their booster (3rd vaccination). The UK Health Security Agency data shows that by November 2021, the vast majority of COVID-19 patients admitted to intensive care units were those who had not been fully vaccinated.

An outreach and engagement plan - *No one left behind* – was devised across BOB ICS to ensure the vaccine campaign was targeted at those populations in areas of deprivation and among groups at increased risk of illness and death from COVID-19 infection. This careful and painstaking work will inform how and where it is best to make approaches and break down the barriers of vaccine hesitancy and address concerns that individuals or communities may have.

During the height of the pandemic, health and social care organisations made rapid changes to how services operated, the infection, prevention and control measures that were in place, and other adjustments made to ensure all patients with COVID-19 needing hospital treatment could be treated. Many primary care and hospital outpatient appointments moved to telephone and online consultations.

As the vaccination programme has rolled out, reducing the risk of becoming seriously ill or being admitted into hospital, this past year has commenced recovery and restoration of services. This report will show the challenges facing the NHS as we try to reduce waiting times for elective / planned care, develop better ways of working collaboratively to support urgent and emergency care across BOB; develop services to support the health and wellbeing of our younger population; ensure the timely diagnosis and start of treatment of people with cancer and further develop our primary care services.

Over the past year work has progressed in developing the integrated care system across BOB. Working together in a more integrated way across the NHS, local authorities and with our voluntary sector we want to ensure we deliver joined up health and care services based on the needs of the individual and shaped by the circumstances and priorities of local communities. Alongside this we have been planning for the transfer of statutory commissioning functions and staff from the CCGs to the new Integrated Care Board across Buckinghamshire, Oxfordshire and Berkshire West.

While another challenging year, we should celebrate the innovation and benefits which it has brought about. I also want to extend my gratitude to colleagues within all three CCGs; many have continued to work in different ways, in different roles and during organisation change which can be unsettling.

As we move into 2022/23 and toward a new organisation and Integrated Care System I am encouraged to see colleagues rise to the challenge; this stands us in good stead for the future as we move forward the work of clinical commissioning groups to a single Integrated Care Board to support the way for the BOB ICS.

Improving the health and wellbeing of people in Oxfordshire

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

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

With the aims of:

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

The Oxfordshire Health and Wellbeing Board oversees several partnership boards of which OCCG and the NHS are represented. The Health Improvement Board and The Children's Trust report directly to the Health and Wellbeing Board regarding the priorities it is responsible for.

Informing the work of the Partnership Boards is the Oxfordshire Joint Strategic Needs Assessment (JSNA) which provides facts and figures about health and wellbeing in Oxfordshire.

Research, data and intelligence is included from a wide range of sources and provides a common and consistent evidence-base for the NHS, local authorities and partners to help pinpoint gaps and target improvements.

While work has continued to deliver the Health and Wellbeing Strategy over the past years, the on-going COVID-19 pandemic has hampered delivery.

In April 2021 a new structure for joint commissioning across health and care was established. This new structure aims to take a more preventative approach to supporting people through the life stages of 'Start Well', 'Live Well' and 'Age Well' to deliver better outcomes. A key element of this joint commissioning function is to avoid duplication in commissioning and make better use of resources to deliver quality services.

Buckinghamshire, Oxfordshire and Berkshire West ICS response to the COVID-19 pandemic and delivery of the COVID-19 Vaccination Programme

In response to the pandemic, NHS England & Improvement was given legal directions over all CCG commissioning functions by the Government to direct health services to meet the emergency needs. Each system established an incident structure reporting to NHSE/I SE Region.

During the pandemic, health and social care organisations across the BOB ICS made rapid changes to how services operated, the infection, prevention and control measures that were in place, and other adjustments made to ensure all patients with COVID-19 needing hospital treatment could be treated. Much of primary care and outpatients moved online with face-to-face contacts restricted to clinical necessity to reduce the risk of spreading the infection.

Changes also included telephone triage so patients were provided with advice, care and prescribed treatment without needing to visit their GP practice. For patients with the relevant technology, hospital appointments were available using video conferencing. New services were also brought online quickly to support people throughout the pandemic such as the 24/7 mental health line across Buckinghamshire and Oxfordshire; GPs worked to set up dedicated clinics for patients with suspected COVID-19 to manage the risk of transmission to patients needing non-COVID-19 related care.

In the summer and early autumn of 2020 as the first wave of COVID-19 receded, all services began to look forward to recovery of services which had been paused by the pandemic and preparations started for the delivery of a UK-wide vaccination programme.

The planning and establishment of the COVID-19 vaccination programme and the siting of vaccination centres across the BOB ICS was initially done at pace, in line with national policy, with the first centres across BOB going live in December 2020. The work has been overseen by the BOB Vaccination Programme Operational Executive, whose members include representatives from the NHS and local authorities across BOB.

The NHS across the BOB ICS achieved its target of offering a first dose of the vaccine to all nine priority groups (as directed by the Joint Committee on Vaccination and Immunisation) by 15 April 2021. All first doses for adults aged 18 were offered by July 2021 and second doses by the end of September / early October 2021. It was a huge logistical challenge being delivered at the same time as managing the increased pressures on health and care services caused by the pandemic.

Now, around 3.7 million jabs have been delivered across the BOB ICS population of 1.8 million people.

There is a network of vaccination centres and services across BOB, comprising Primary Care Networks (GP-led services), pharmacies, large vaccination centres, hospital sites, pop-up clinics, a mobile service (Health on the Move), and a schools' programme for children aged 12 and over. As a result of hard work and commitment from GP practices working together with health services partners and an army of volunteers, the BOB ICS has consistently been among the highest performers across England in terms of vaccination uptake and outreach.

The vaccination clinics and services continue to be geographically spread across the BOB ICS area to provide equitable access. Consideration has been given to location, travel, parking and the ability to deliver the vaccine and manage the needs of large numbers of people across all the cohorts.

In December 2021, as the Omicron variant began to emerge and spread, health and care systems across the country were required to accelerate the vaccination programme by offering booster jabs to everyone over the age of 18 before 31 December 2021. The Government's target required the BOB ICS to be able to offer over 500,000 boosters to all the eligible cohorts of people during a period of three weeks.

Many GP-led vaccinations sites had wound down their vaccination clinics as the GP practices across the BOB ICS focused on 'business as usual' services for their patients, but they answered the call to support the rapid expansion of the booster programme. The need to make boosters available at

speed required a lot of staff time and resources, so GP practices were asked to clinically prioritise services. This led to some routine appointments and services being postponed. However, patients were assured that clinically urgent services were open and urgent appointments went ahead as planned.

The BOB Vaccine Equality Group was established to promote the vaccine, ensure equity of access to the vaccination programme and to provide outreach and follow up for those not yet vaccinated or who only had one dose. This has led to local discussions with those communities who have been vaccine hesitant or who have had access difficulties

Three place-based groups were established in Buckinghamshire, Oxfordshire and Berkshire West through which to plan, monitor, review and best manage the programme overall and ensure alignment in the work of the large vaccination centres, GP-led sites and mobile vaccination.

Efforts have been made in each of the places to ensure equity of access and provision of high quality and bespoke communications to address vaccine hesitancy and enable people to make an informed choice.

Engaging with local communities has been fundamental in reducing inequalities in vaccine uptake.

Work undertaken as part of this workstream has included:

- mapping of engagement events and contacts within each of the three local Place areas
- mapping of key stakeholders to create a distribution network for communications
- a public survey to identify issues and barriers to uptake of the vaccine
- Health and Wellbeing Ambassadors / Vaccine Voices / influencers programmes have been developed to encourage informed decision making through conversations with communities, friends, family and contacts in low take up cohorts.

Additionally, pop up and outreach services, including Health on the Move mobile facilities, have been used to target vaccination hesitant populations and areas where there has been lower take up. This has included homeless people, areas of inequality, Black and Minority Ethnic Communities, and larger employers.

Oxfordshire's response

Oxfordshire has one of the highest vaccine coverage rates in the country and the success of the 14-month campaign should be celebrated. In the period from December 2020 until the end of March 2022, our NHS system, working in partnership with local government colleagues and the voluntary sector in the county, delivered more than 1.6 million jabs via 20 GP-led local vaccination sites, the large vaccination site at the Kassam Stadium in Oxford, two hospital hubs, community pharmacies and various pop-up clinics. At the end of March 2022 82.0% of 18-year-olds and over registered with an Oxfordshire GP practice had received two doses of COVID-19 vaccine and 86.2% of eligible over 18s have received a booster dose.

This remarkable achievement would not have been possible without an army of volunteers. In June 2021, we thanked more than 1,000 volunteers who worked at GP-led local vaccination sites, many of whom were members of Patient Participation Groups and others who came forward from the local community. People of all ages volunteered, from young students through to people in their 80s. Oxfordshire Local Enterprise Partnership provided a small budget to support a modest gift and card for to each volunteer. A short film was made to record the event.

There remain, however, more than 120,000 eligible people across Oxfordshire who have not yet taken up the opportunity to be fully vaccinated and are not protected against becoming seriously ill with COVID. Our outreach and engagement plan - *No one left behind* – aims to address the concerns of people who may be vaccine hesitant or to make access to jabs easier.

Oxford GPs have held outreach vaccine clinics in homeless shelters in the city and work is on-going with Turning Point in Banbury to ascertain the need for clinics in the town for homeless or rough sleepers.

The NHS and local authority colleagues have been working with the Margaret Clitherow Trust to make vaccines easily accessible to the Gypsy, Roma and Traveller communities in Oxfordshire and there has been good uptake of first and second vaccinations on registered traveller sites.

Work is also underway to establish an Oxfordshire based (OUH) maternity champion to engage with women attending outpatient appointments and scanning during their pregnancy to discuss and/or provide them with the COVID-19 vaccination.

Oxford City Council has been awarded £485,000 from the Government's Community Vaccines Champions fund to recruit champions who will be representative of Oxford's diverse population and will engage with their communities in collaboration with the NHS, Public Health, Healthwatch Oxfordshire and voluntary sector partners.

It was identified that there was a low uptake of the vaccination within the younger Chinese community. In Oxfordshire, OCCG's Outreach team worked to promote the vaccine and increase confidence in getting vaccinated. This included working with Chinese community leaders, as well as developing materials to be disseminated through social media (including Whatsapp and email) and posters displayed in Chinese restaurants and takeaways across the area.

Work started in early 2022 to establish Maternity Champions to support the vaccine programme in the county. They are based in local hospital maternity units and engage with pregnant women onsite on COVID-19, flu and whooping cough vaccination to provide information and the offer of vaccination for those who want it. They will also be offering carbon dioxide monitoring, Stop Smoking and other lifestyle advice.

Two Health on the Move (HOM) vans were procured by BOB ICS in July 2021, with Oxford Health as the lead provider of the service. The HOM project intended to use a roving delivery model to increase access to COVID-19 vaccination for those who had not yet engaged with the vaccination programme. This project primarily targeted seldom-heard and potentially vaccine-hesitant communities and those who had not been vaccinated due to access and convenience issues. There was an understanding that the HOM van could also be used for health promotion, oximetry and other uses beyond the COVID-19 vaccination programme.

During the initial outreach stage of the project, the OCCG HOM team found that many communities, such as the Polish, Nepalese, Romany, Gypsy, Traveller and boating communities, had already been vaccinated.

This meant that it was mainly vaccine-hesitant groups which remained, therefore much of this project focused on community engagement, building relationships, and providing accurate vaccine information to be disseminated by trusted community leaders. When these interactions resulted in HOM clinics, the clinic attendees reported that it was beneficial to be able to ask the vaccinators questions and voice their concerns in a familiar environment with less time pressure than at a mass or local vaccination site. The HOM project not only increased access to the vaccine, but also access to vaccine information; a vital tool for addressing vaccine hesitancy.

By the end of March 2022 in Oxfordshire

- 1,602,458 vaccines had been delivered
- 267,814 of 50-year-olds and over had received two doses

- 250,754 of 50-year-olds and over had received their booster
- 7,022 of our 75-year-olds and over had received their 2nd booster (fourth vaccine) even though the 2nd booster programme had only commenced 21 March
- 530,428 of those 18-year-olds and over had received their booster (3rd vaccine)
- For 12-15 year olds 23,159 had received a 1st dose and 14,811 a 2nd

In Oxfordshire we established one of the first multi-disciplinary Post-COVID-19 Assessment and Rehabilitation services in January 2021. The Oxfordshire Adult Service is an integrated service delivered by OUH and Oxford Health. The service accepts referrals from the community (primary care) or following post-COVID-19 hospital discharge.

The service includes specialist triage, multi-disciplinary Post-COVID-19 Assessment Clinic and a Post-COVID-19 Rehabilitation Pathway. It includes specialists in respiratory medicine, rehabilitation medicine, sports and exercise medicine, psychology and psychiatry, respiratory physiotherapy, chronic fatigue occupational therapy, vocational support and a specialist nurse care coordinator.

The rehabilitation pathway includes holistic assessment, symptom tracking, virtual fatigue management, virtual breathlessness management, psychological therapies (dietetics, pulmonary rehab, one-to-one specialist support, peer support, and Imperial College and English National Opera breathing rehabilitation programme.

Personalised care and supported self-management are also encouraged throughout the pathway, including use of the Your COVID-19 Recovery online platform.

Recovery of Elective Care

Early in the pandemic, routine referrals and elective operations and treatments were paused across the BOB ICS in line with national guidance from NHS England & NHS Improvement (NHSE&I). Hospital Trusts across BOB were asked to redirect staff and resources to free up the maximum possible inpatient and critical care capacity for COVID-19 patients and prepare for, and respond to, the anticipated large number of COVID-19 patients who would need respiratory support.

Trusts postponed non-urgent elective operations, rapidly discharged patients who were medically fit to leave and focused on urgent and emergency care, cancer care and implemented virtual online outpatient clinics where clinically appropriate.

While elective operations, treatments and care resumed during 2020/21, further waves of the pandemic hampered efforts in elective care recovery. As a result, there are lengthy waiting times for outpatient appointments and treatment across the BOB ICS. A key area of focus in the latter part of 2021/22, and moving forwards, has been to support elective recovery by working collaboratively to address waiting times and offering patients treatment options.

This includes:

- the creation of new community diagnostic centres to carry out a range of diagnostic tests, out of hospital, including
    - imaging (CT, MRI, ultrasound, X-ray, and mammography)
    - physiological measurement (echocardiography, full lung function tests, and ambulatory blood pressure monitoring)
    - pathology (phlebotomy, point of care testing, and simple biopsies)

- 7 days per week working in some specialties
- increasing the use of independent sector outpatient capacity for some specialties
- identifying capacity in neighbouring hospitals to re-direct patient and reduce waiting times

Despite the on-going pandemic and third wave of the virus hitting the country late 2021 and into early 2022, elective recovery work has continued and is ongoing as we try to reduce the numbers of patients experiencing long waits for treatment.

In the face of this challenge some work has continued to redesign and deliver services in a different way to meet the challenge of the pandemic:

Specialist inpatient palliative care: Two new specialist palliative care inpatient beds were introduced at Wallingford Community Hospital in South Oxfordshire in December 2021, through close partnership working between OCCG, Oxford Health, and the Sue Ryder Charity.

The service is delivered by Oxford Health, in partnership with Sue Ryder Care's 'Hospice at Home' service for patients who are approaching their end of life, and who need bed-based care. The service means people in the local community who require inpatient palliative care will be able to receive it closer to home. Admissions to the beds are made through Sue Ryder.

The Sue Ryder team, which includes a clinical nurse team and consultants, works with Wallingford Oxford Health ward team, including an End-of-Life specialist nurse, GP and Advanced Clinical Practitioner, to provide compassionate and expert palliative care to patients from the local area. As part of this, a specialised end-of-life training programme is being developed to be rolled out to other teams in the Trust's community hospitals to increase their knowledge and strengthen skills in end-of-life care.

Two beds at Wallingford enhance the range of health services available for residents of South Oxfordshire and form part of a wider provision for palliative and end-of-life care services available.

The end-of-life care services available include the Sue Ryder Hospice at Home service, Hospital at Home service, community end-of-life care matrons and the Marie Curie Night-Sitting Service. There are also out of hours services ensuring primary care is available 24 hours a day.

Blood pressure monitoring at home: OCCG's planned care team launched its *Take the Pressure off* campaign in July 2021 to enable people to monitor their blood pressure (BP) at home. The initiative is supported by NHS England and Public Health in Oxfordshire.

Home monitoring offers a way for people to take control of their health, feel confident, and take the pressure off the NHS at the same time. It gives people a practical way to know their BP numbers without visiting their GP or pharmacist.

The pandemic lockdowns disrupted many people's healthcare routines. But regular monitoring is important - especially for those patients with diagnosed high BP - to ensure potential problems can be detected early, which in turn helps prevent heart attacks, strokes and other illnesses.

OCCG has worked with Oxfordshire's GP practices to start nearly 1,400 patients on home monitoring and has provided nearly 550 free BP monitors to patients living in areas of higher deprivation and those people who are unable to buy their own equipment. Patients with higher clinical risk were also prioritised in the initial phase of the project.

After a patient is identified as suitable for home monitoring by a GP, practice staff provide information on how to use the equipment, how to report results back to the GP practice, and what the results mean, whether levels are healthy and when there is need to seek advice or act.

Feedback from patients has been positive, with people feeling more confident about managing their own health and having a point of contact with a health professional at their GP practice when they need advice.

There remains the opportunity for many more patients with high BP to benefit from home monitoring, representing a great opportunity to build on this work in 2022/23.

Diabetes Prevention and Care: Oxfordshire NHS' continuing commitment to diabetes prevention and care services scooped a Health Service Journal (HSJ) Value Award in the 'Diabetes Care Initiative of the Year' category in September 2021.

The winning team included senior clinicians, managers and analysts from:

- OCCG
- OUH
- Oxford Health
- South Central and West Commissioning Support Unit
- people living with type 1 and type 2 diabetes, who helped to guide the project.

The team focused on patient data such as treatment outcomes, the percentage of those attending as outpatients to manage their condition, and other relevant diabetes care processes to create a dashboard. The implementation of the dashboard and multi-disciplinary working has played a significant role in improving the care of people with diabetes within Oxfordshire, which is measured in the National Diabetes Audit (NDA).

The dashboard is updated monthly to provide a view of all the relevant information around diabetes care and health outcomes for people living with the condition in Oxfordshire. It presents data at county, PCN and GP practice level, so providing a regular insight into Oxfordshire diabetes population health.

The dashboard has been used in regular visits in GP practices and PCNs by the diabetes specialist team, including consultants, specialist nurses and dietitians to develop supportive multi-disciplinary working and joined-up care.

There are 33,700 people with diabetes in Oxfordshire (about 4.2% of the population).

People with diabetes should have an annual check-up, which includes urine and blood tests, as well as an examination of their feet. This has improved in Oxfordshire between 2016 to 2020: the percentage of people with Type 2 diabetes having all their annual checks increased from 51.6% to 76.7% (nationally the figure changed from 53.9% to 54.3%); for people with Type 1 diabetes, this increased from 29.3% to 57% (nationally, from 37.3% to 40.8%).

It is estimated that there are a further 10,000 people with diabetes in Oxfordshire who do not know that they have diabetes because they have not been tested; work continues to identify and support them.

Cancer services

Like other health service areas, cancer services across the country have been under significant pressure to deliver treatment for all patients due to the COVID-19 pandemic. This is no different for the BOB ICS, which has been working with the Thames Valley Cancer Alliance (TVCA) to ensure delivery of cancer services across the area.

Throughout the pandemic, cancer services across BOB have continued to be delivered based on clinical prioritisation with priority 'P2' surgery, radiotherapy and chemotherapy all continuing uninterrupted. Latest performance[2] places the TVCA compliant at 75% to the new 28 day faster diagnostic standard.

The areas of greatest challenge across the Thames Valley remain in the high-volume cancer pathways of lower gastrointestinal (GI) tract, skin, and breast. However, it does indicate that we are closing the gap on 'hidden backlog' as more people come forward with symptoms. TVCA, on behalf of BOB ICS, is leading the plan for cancer in 2022/23 focused on:

- introducing the tele dermatology-led skin pathway
- achieving the national ambition of 80% of all lower GI referrals referred with a FIT (Faecal Immunochemical Test) test completed in primary care
- delivering 75% population coverage of nonspecific symptom pathways to deliver faster diagnosis and improved performance to the constitutional standards for cancer

TVCA will also focus on earlier diagnosis by identifying the second site for targeted lung health checks based on areas of highest deprivation, inequality and known poorer outcomes within the BOB ICS geography.

In Oxfordshire, a quality improvement initiative was continued across all PCNs from April 2021 to March 2022. This was the third year of this initiative which aims to increase uptake of screening, improve two-week cancer detection and improve the quality of life for patients living with cancer. One of the key aims for screening was to return to pre-COVID-19 levels. There was a particular focus on improving screening uptake for patients with Learning Disabilities, and PCNs were also asked to select other groups of patients where screening uptake was low.

The cancer care reviews in primary care programme was run for the second year and launched following a webinar in December 2020. Patients are offered a cancer care review at two separate points in their cancer journey. This links to NHS Long Term plan which sets out the requirement for all cancer patients to have access to personalised care including a needs assessment, a care plan and health and wellbeing information and support. The scheme has enabled more than 4,000 additional reviews to take place for patients across the BOB ICS footprint. A new scheme will be taken forward in 2022/23 with renewed focus on specific groups of patients to further improve post treatment care.

The past year has seen the system working together to implement risk stratified follow-up across prostate, breast and colorectal cancers. The NHS Long Term Plan for Cancer states that after completing treatment, each patient should move to a follow-up pathway that will meet their needs. Such pathways should ensure that patients can rapidly access clinical support if they are concerned that their cancer may have returned.

Personalised Stratified Follow-Up allows patients to have a personalised follow up pathway based on their level of risk, improving the patient experience, alongside creating additional capacity in cancer clinics, allowing healthcare professionals to see more patients and those with complex needs. This will allow faster diagnosis and treatment as well as better care. Patients put on to stratified follow-up pathways will be given signs and symptoms to look out for so that they can rapidly access their healthcare team in the future if needed. They will still undergo their regular surveillance scans and tests with faster access to results. Patients will avoid unnecessary appointments.

There has been some delay in implementation due to COVID-19 but the system is now on track to have the pathways implemented by June 2022 for Buckinghamshire; Oxfordshire and Berkshire West are also progressing well. Following this, risk stratified pathways will be introduced for other tumour sites.

[2] Data from December 2021

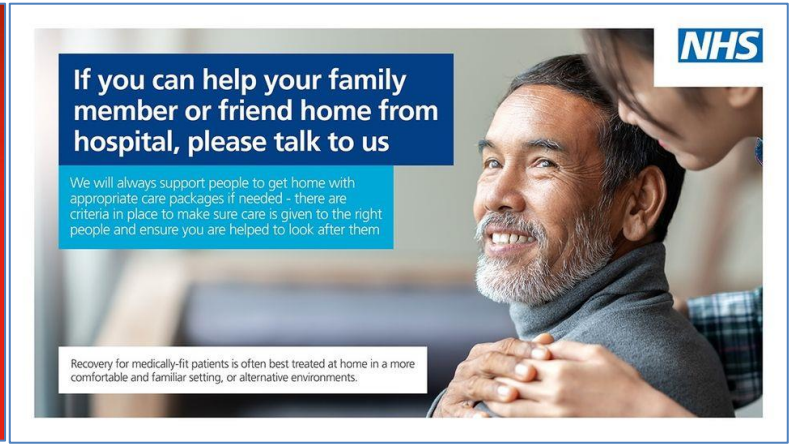
Tackling urgent care pressures in the county

The effects of the pandemic on the health system have made it even more important for health and social care professionals across the BOB system to work together to deliver responsive and joined-up urgent and emergency care services. Over the past few years, pressure on urgent and emergency care has gone beyond the increased need for services during the winter and is now a year-round challenge.

Across the BOB ICS, teams from hospital and community Trusts, the CCGs and local authorities have worked together to ensure people who required urgent and emergency medical treatment were able to access services.

Alongside this, communications teams from the CCGs and system partners have worked together to deliver campaigns to local people encouraging them to look after themselves and stay healthy, and to use healthcare services in the most appropriate way. Key messages over the past year have been:

- Emergency Departments (EDs) are for genuinely life-threatening conditions, for non-life-threatening conditions please use alternative services such as local pharmacies, minor injuries units, your GP and NHS 111 who can advise and direct patients to the best place for care



- Our EDs and hospitals remain very busy. If you can help your family member or friend home from hospital, please talk to us. We will always support people to get home with the appropriate care packages

People were urged to have a winter plan for themselves and their family to keep as well as possible, what they could do if they became unwell, and how to look after more vulnerable neighbours and friends.

Across Oxfordshire, like the rest of the country, we have seen an increase in admissions to our EDs, and the average length of stay has also increased. Extensive work has been undertaken during 2021/22 to help alleviate pressures and improve patient flow through the county's hospitals. Below outlines some of those initiatives:

Home assessments: One of the main projects underway is to assess people in their homes and to ensure they receive the same standard of care as they would if they were in hospital. The Single Point of Access, Urgent Community Response and Hospital at Home teams are working together to provide a central point for health care professionals to refer into, ensuring those who need an urgent assessment in their own home are assessed by the most appropriate clinician.

This supports the multi-disciplinary teams from across the system to work together to:

- Provide an assessment and make decisions in the patient's own home equivalent to that delivered in a hospital setting
- Share physical and virtual space where professionals can connect more effectively and work in proximity to each other, improving multi-disciplinary working and ensuring the right people are caring for each patient at the right time
- Improved coordination and less duplication between services.

'Call Before Convey': The Oxfordshire system has worked together to pilot assistance for paramedic crews to reduce the number of people being taken to hospital with complicated care needs. Instead, patients who had called 999 are being assessed and treated in their own home. Following the initial 999 call, a clinician is available to facilitate each call with support from an Urgent Community Response specialist, and other medical colleagues as appropriate. A decision is then made to confirm whether the patient needed to be assessed at home or attend ED. A suitable assessor was asked to visit the patient at home within two hours for those who were well enough to be assessed in their home. While this pilot is on-going it has, thus far, proved successful; the Oxfordshire health and care system has adopted the *'Call before Convey'* principle to help deal with the pressures facing urgent care services.

Urgent Community Response Services: The Urgent Community Response (UCR) service is a collaborative project involving Oxford Health, OUH, Principal Medical Limited (PML) and OCC, which operates from 8am until 8pm, 7 days a week. This service aims to assess and treat patients at home or as close to home as possible and avoid hospital admission. The medical oversight is provided by OUH; the team has direct access to a consultant, in addition to a daily multi-disciplinary team meeting to review patients on the Oxford Health and OUH virtual ward. In addition, the UCR has access to carers who can offer short term interventions to help patients while they recover.

General Practice Services

In the initial response to the pandemic and as part of the level 4 incident declared by NHS England nationally, GP practices made rapid changes to how services were accessed and delivered. Many of the changes were intended to reduce the face-to-face contact which in turn reduced the risk of spreading the infection.

A key feature and point of difference during the pandemic was accelerated delivery of remote and virtual services. As a clear step to reduce the spread of COVID-19, GP practices were required to introduce total triage. Patients were assessed by a GP over the phone or online first, allowing many people to be offered advice, prescriptions or referral without the need for a face-to-face appointment. For patients with the relevant technology, appointments have been available using video conferencing with healthcare professionals.

In Oxfordshire, part of this new way of working included the introduction of an online advice and appointment system eConsult. The form-based online consultation platform collects a patient's medical or administrative request and sends it through to their GP practice to triage and decide on the right care.

In Oxfordshire appointment levels returned to pre-pandemic levels in September 2020. This was a key deliverable in the restoration and recovery of services. These levels have been sustained at pre pandemic numbers since that time. The appointment patterns follow the seasonal trends seen in previous years and the majority of appointments are delivered face to face.

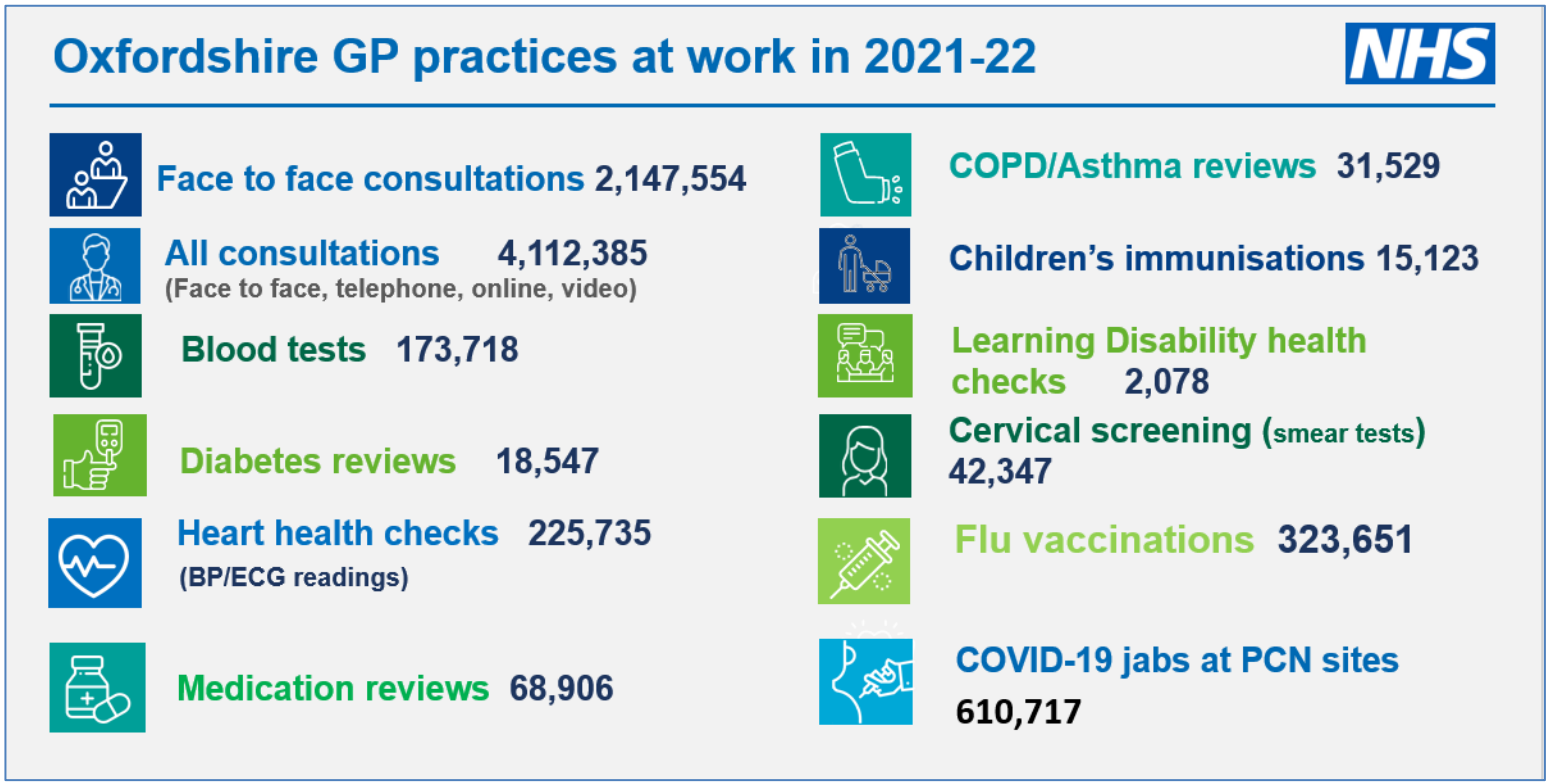
	Total general practice appointments Oxfordshire				
Year	**April - September**	**October - March**	**Full year**	**COVID-19 Vaccination (given by general practice)**	**Grand total**
2019/20	1,913,382	2,031,835	**3,945,217**		**3,945,217**
2020/21	1,556,001	2,100,639	**3,656,640**	281,248	**3,937,888**
2021/22	1,966,244	2,146,141	**4,112,385**	610,717	**4,723,102**

Table 1 Summary of general practice appointments and vaccinations delivered by PCNs

The table above shows the total number of appointments delivered by General Practice. There was a reduction in the number of appointments in the first half of 2020/21, this was during the period of first lock down. Appointment figures returned to pre pandemic levels, and were higher in the second half of that year.

Primary Care Networks (PCNs) as groups of GP practices played a significant delivery role from the outset of the COVID-19 vaccination programme. When the figures for the numbers of vaccinations are added to the general practice appointments it is easy to see the significant increase in delivery by general practice. For March 2022 – Oxfordshire provided on average 2.09 appointments per patient compared to 2.04 before the pandemic[3] (national range 1.59 to 3.00) and below outlines the different areas of work undertaken in general practice over the past year.

[3] November 2019



A programme of work to improve access to general practice over the winter period known as The Winter Access Fund (WAF) was introduced by NHS England in October 2021. The aim was to drive improved access to primary care by increasing capacity and also increase resilience of the NHS urgent care system. The programme of work ran between November 21 and March 22 and a full qualitative and quantitative evaluation is currently taking place.

Across Oxfordshire schemes included more appointments in general practice and out of hours, additional administration staff, a phlebotomy service, and a collaborative on the day service know as an 'Acute Hub'. The Winter Access Fund provided an opportunity to pilot various schemes at practice and PCN level.

Early data suggests the Oxfordshire schemes delivered at least

- 2,427 additional GP sessions (a morning or afternoon surgery)
- 38,832 additional GP appointments
- 4,874 additional hours provided by other clinicians
- 14,622 additional clinician (non GP) appointments

- 9,413 additional hours of reception staff time

The scheme operated across all of BOB ICS and the funding was specifically to increase capacity and improve access through the height of the winter period. The funding sought to enhance those areas where access had been found to be most challenged. The system has learned a great deal from the experience of investment specific to primary care during the winter period. The evaluation work will include reviewing those services added that made the most difference.

Supporting children and young people with their mental wellbeing

Oxfordshire's Children and Young People Mental Health service (CAMHS) was fully operational throughout 2021/22 and continued with the online support it set up at the start of the pandemic – with face-to-face appointments for those young people who are unable to access online help.

CAHMS was expected to carry out around 62,000 appointments during the year of which 43 per cent will have relied on digital technology such as video consultations. This way of working received positive feedback from young people and parents who valued not having to travel to face-to-face appointments.

This approach was part of a wider plan at Oxford Health NHS Foundation Trust to embed digital transformation across the service so more young people and their families can benefit.

The CAMHS website was redesigned to make it more attractive to young people and to ensure services were accessed more promptly. The new look website included self-help resources for parents, carers and young people, and up-to-date information and support around common mental health issues for young people.

Other digital initiatives over the year included the roll out of Healios, an online provider which continues to allow better access to assessments and treatment for young people. There was funding to evaluate an online tool (OVAAT) which assesses the strengths and weaknesses of a patient's autism to pinpoint more effective treatment. During the early part of the pandemic this tool received positive feedback from clinicians, young people and families.

CAMHS also made better use of digital apps over the past year such as Sleepio, used to treat insomnia in young people, and BlueIce to help manage emotions and reduce self-harm in patients. During the year, 30 tablet computers were distributed to clinicians across the service to support online consultations with patients.

The success of the keyworker initiative enabled the autism and learning disability service to be awarded 'exemplar site' status from NHS England for good practice. This initiative provided more support to children and young people with a learning disability, autism or both. The accolade means the service will contribute to the development of the national keyworker programme, which is a commitment in the NHS Long Term Plan.

In addition, the autism service was the first in the country to employ social prescribers and recovery workers to ensure young people and their families developed closer links with their community to avoid missing out on health and wellbeing support.

The Eating Disorder service coped with high demand throughout the year and achieved its urgent standard (seen within one week). Investment has allowed further service improvements to ensure symptoms are spotted earlier and prevented from getting worse. This approach has been embedded in GP practices and local community and acute hospitals. Further funding is aimed at increasing capacity in the service to treat those most at risk of being admitted to hospital. The service trialled new ways of dealing with urgent cases, including the roll out of a hospital-at-home service to support families in managing complex eating disorder needs.

While there is good work being undertaken in the CAMHS we recognise the challenges around accessing some services (Getting Help, Eating Disorders, Neuro Development Conditions(NDC) which is primarily due to more young people with complex needs seeking mental health support and a general increase in demand that is in line with national trends. We are managing this with a number of initiatives that include:

- implementing an emotional mental health and well-being strategy that aims to increase access to early primary preventative mental health services that will promote good mental wellbeing and support those at risk of developing poor mental health in the future. The strategy will also include increasing capacity and building on the strong voluntary and community sector mental health services in Oxfordshire
- Introducing new Mental Health Support Teams in the South of the County
- Introducing an early intervention/self-help digital offer
- Rolling out a new pathway for those CYP with eating disorders and autism that will provide additional staffing capacity and expertise to support achieving national access targets for assessment and treatment
- Funding a number of local providers to deliver education and support for those families awaiting diagnosis on the NDC wait list. This includes the provision of individual and group work with families and digital assessments and treatment.

Other areas that are performing well include the Key worker pilot where we have achieved a reduction in the number of hospital admissions for those CYP with autism. Our CAMHS Learning Disability service is achieving assessments targets with feedback from families telling us that we are supporting them to manage challenging behaviour better. Despite reduced staffing numbers due to COVID, recruitment pressures and the increased local demand for access to our Eating Disorder Service, the team has continued to meet the 95% national target for those CYP requiring urgent assessment and treatment within 7 days.

Delivery of mental health services for adults

Throughout the past year work has continued to support mental wellbeing and improve outcomes for people suffering from mental health conditions. This is underpinned by a range of providers across the NHS, councils and voluntary sector that enables flexible ways of working and skills mix to help us meet people's needs promptly. This approach also allows people to remain as independent as possible to prevent the need for longer term specialist services.

Oxford Health Foundation NHS Foundation Trust was delighted to be awarded 'Trailblazer Status' by Health Education England for its peer support worker programme. Peer support workers who have experienced mental health issues work as part of multidisciplinary teams both on inpatient wards and in the community. Peer support workers provide support to patients, drawn from their own lived experience which can help improve the quality of patient care. The Peer Support Programme is changing the culture across mental health services with a focus on recovery, giving patients a sense of hope, aspiration and control over their own lives. The programme breaks down barriers between staff and patients demonstrating we all have mental health and wellbeing.

The success of the programme has resulted in expansion of roles across a variety of mental health services and further training programmes are being run in both Oxfordshire, Buckinghamshire and forensic services.

The Community Mental Health Framework will improve the health and wellbeing of people with significant mental illness (SMI) conditions by developing an integrated community mental health service that brings together all mental health support providers, from across the NHS, social care, voluntary and third sectors. The approach in Oxfordshire will enable primary care to offer enhanced mental health assessment and support to people with serious mental health conditions by offering early intervention, supporting recovery, and helping them to live well with their condition in their community.

This work has been underpinned by OCCG working closely with Oxford Health to pilot the introduction of primary care mental health teams based in 'high street hubs'. These 'hubs' will provide locally accessible support to adults and their carers, making it easier for them to get the help they need, when they need it, locally within their community, in welcoming spaces.

This builds on the successful introduction of Oxford Health specialist mental health practitioners across the county this year, working in GP practices to support SMI patients in their community. This aims to plug the gap between traditional primary and secondary care mental health services.

The Safehaven Service which helps people who are experiencing a mental health crisis expanded its opening hours and is now open 7 days a week from 6pm until 10pm. The service provides a safe welcoming space for face-to-face support and can also be accessed by phone by people who are feeling distressed and are struggling to cope.

During the year a significant number of skilled nurses were recruited from abroad by Oxford Health to work in their community hospitals and mental health wards. The international recruitment drive has resulted in 74 nurses from countries including India, Kenya, Nigeria and Ghana offered roles at the trust. They are being supported in gaining registration with the Nursing and Midwifery Council. The initiative which moves to a new phase in 2022 has strengthened Oxford Health's workforce to provide resilience and flexibility in the services it provides.

Developing services and support for people with learning disabilities and autism

The BOB ICS Learning Disabilities and Autism 3-year delivery plan was created as a response to the Long Term Plan, NHS England's strategic guidance for local need, and Integrated Care System (ICS) opportunities.

This plan was developed across system partners to meet the emerging needs of the local and ICS population and how that need would be met with the ICS, local government, health care, social care and third sector working in partnership.

The plan in year 1 (2021/2022) focused on setting the foundations and framework for our population in key areas of reducing health inequalities, improving support for autistic people and autism pathways, reducing reliance on mental health inpatient care and making this care more appropriate for people with a learning disability and/or autistic people. It also included making reasonable adjustments to support access to healthcare services and providing crisis provision for anyone who needs it, when they need it.

Each of the BOB Clinical Commissioning Groups (CCGs) in Buckinghamshire, Oxfordshire and Berkshire West have been driving this agenda with their local partners as demonstrated in their own initiatives.

Across Oxfordshire our target was to have completed 2,046 learning disability health checks over the past year, by end of February 2022 we had done 1,669. We are continuing to work with colleagues in GP practices and community teams to improve on these figures and to ensure vulnerable people receive their health checks, with a focus on quality and frequency. Annual Health Checks are a proactive way in which GPs are able to pick up health issues earlier and reduce health inequalities.

We are working with Oxford Health to develop the Reasonable Adjustments Service (RAS). As the team expands, they will work with health providers to ensure reasonable adjustments are made so staff are confident and have greater skills and knowledge to provide autism support in the right way. The RAS team have developed an autism friendly site online with a 'passport' and a range of tools and support to manage and plan around health needs.

We have invested in tools such as ‘Brain in Hand’ and ‘Autonome’ licences and apps to be used to support greater independence, skills development and coping skills; for in the home and when people out in the community, when travelling, working or training. We look forward to hearing their stories to understand better how technology can provide new ways to empower people with autism and learning disabilities in Oxfordshire.

As OCCG works jointly with OCC, we are linking closely into housing and accommodation plans to support people with more complex needs to stay in the Oxfordshire area and closer to home. A small number of bungalows have been developed and a support provider is now in place for a planned transition back into Oxfordshire for one person currently in hospital. Joined up planning for learning disability accommodation must make sure that autism needs are included in property design specifications and adaptations to ensure new property developments are fit for purpose, future proofed and are a flexible resource for a range of needs.

Medicines Optimisation

The safe and effective use of medicines is an essential element of healthcare. OCCG’s Medicines Optimisation (MO) team supports clinicians, patients and carers in making decisions about which medications to use to obtain the best possible outcomes.

During 2021/22, the MO team continued to support appropriate prescribing across OCCG in the usual ways including the review and implementation of guidelines, collaborative work with providers, the introduction of new pathways and the review of governance arrangements. As in previous years, individual prescribing meetings were held with all practices to discuss current issues (including the Prescribing Incentive Scheme) and identify priorities; prescribing data was used to support this.

Due to the pandemic and additional workload in primary care, the incentive scheme was suspended for two months in January 2022. However, the Prescribing Dashboard continued to be updated regularly and made available via the OCCG website to inform practices on all their prescribing targets, achievements and priorities. The MO team continued to be readily available for primary care and clinical colleagues with specific questions.

In addition to the usual work programme, the MO team continued to be actively involved in the COVID-19 vaccine roll out, supporting the PCN sites with vaccine preparation and vaccinating as well as transporting the vaccine between sites under the mutual aid arrangements.

The three MO teams across the ICS have continued to work closely together, with joint meetings and many joint projects. In addition, collaborative working with PCN pharmacy colleagues has continued and further links with secondary care have been made.

Optimising medicines use to maximise health outcomes and give the best value has never been more important and the OCCG MO team continues to work with colleagues across the system to achieve this.

Improving Quality

OCCG is responsible for ensuring continuous improvement in the quality of services it commissions in connection with the prevention, diagnosis or treatment of illness. Quality is defined in the NHS as safe and effective care alongside outstanding patient experience. Improving the quality of healthcare provided to people in Oxfordshire is at the heart of what OCCG does.

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 over the past

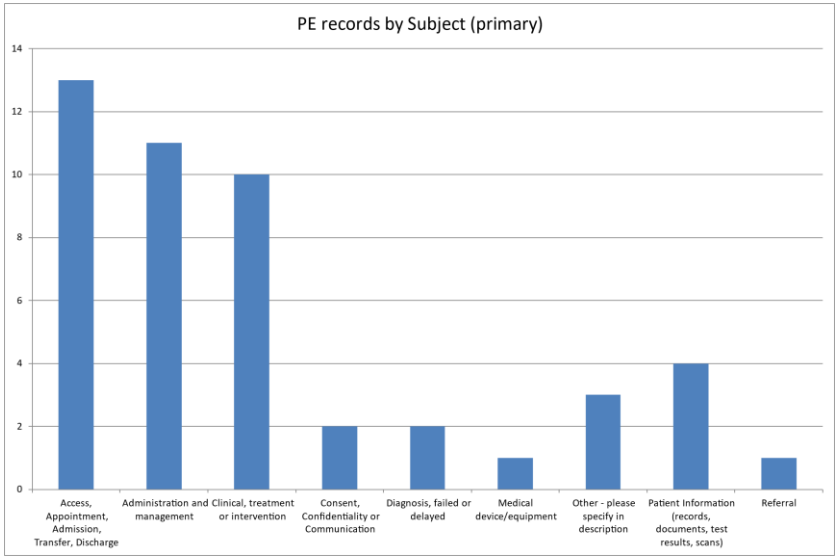
year.

Datix is OCCG's online quality reporting system which continues to be an effective tool for GPs to report issues to OCCG and is helping to improve the quality of services. It allows GPs' feedback to be captured across the 67 practices, enabling the identification of the causes of commonly occurring incidents and trends.

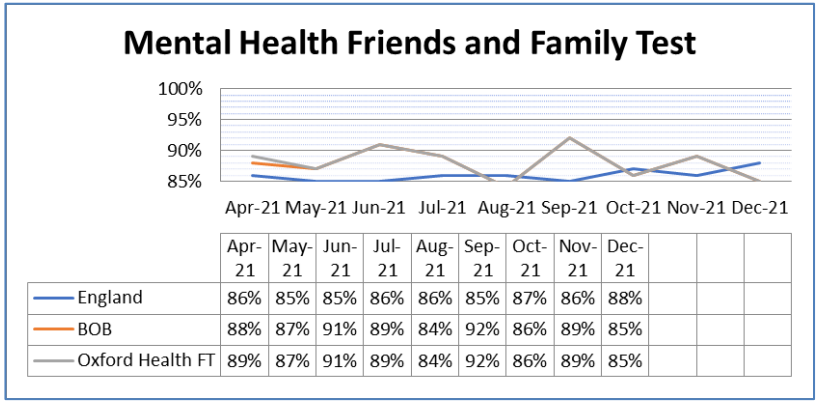
OCCG works with health providers to prevent them happening again, and to identify problems early to find solutions and improve care for patients. From April 2021 to March 2022, 867 items of feedback were reported via Datix. This information is used with information from serious incidents, patient experience and performance data to identify where services and care could be improved. OCCG addresses issues identified and regular progress reports are shared with GPs, health providers and the Local Medical Committee (LMC) to demonstrate change is taking place.

As a result of this GP feedback, we have worked with OUH to make a change in practice to ensure the ED directly passes on patients with any cancer related symptoms, reducing the risk of patients being lost in the system. Similarly, following GP feedback we have worked with Oxford Health to improve telephone access for GPs for the single point of access, ensuring that practitioners can directly contact the team to escalate concerns and manage patient issues.

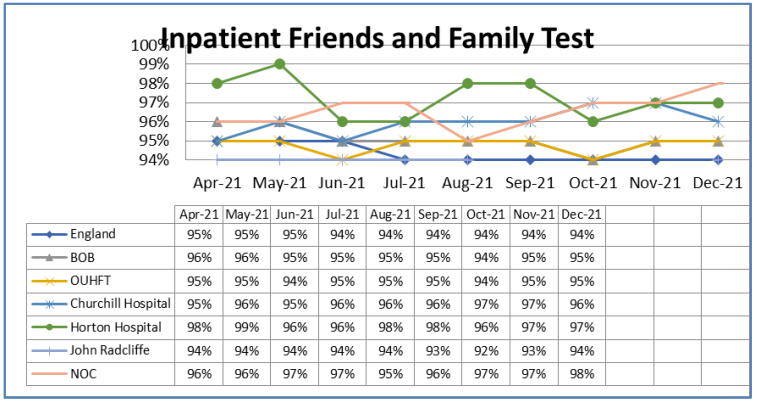
OCCG also collects feedback from members of the public about their experiences of healthcare through compliments and complaints and patient experience surveys. OCCG received 47 formal complaints during 2021/22 as shown below. No complaint was referred to the Ombudsman.



While some monitoring of patient experience was paused due to the pandemic; OCCG monitors patient satisfaction through the Friends and Family Test (FFT) where patients are asked, on leaving a service, how likely they would be to recommend the ward or service to a friend or a member of their family with the same need. The results are presented as a percentage who responded either 'extremely likely' or 'likely' to recommend. Below gives a couple of examples for mental health services at Oxford Health and inpatient services at OUHFT.



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
England	86%	85%	85%	86%	86%	85%	87%	86%	88%
BOB	88%	87%	91%	89%	84%	92%	86%	89%	85%
Oxford Health FT	89%	87%	91%	89%	84%	92%	86%	89%	85%



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
England	95%	95%	95%	94%	94%	94%	94%	94%	94%
BOB	96%	96%	95%	95%	95%	95%	94%	95%	95%
OUHFT	95%	95%	94%	95%	95%	95%	94%	95%	95%
Churchill Hospital	95%	96%	95%	96%	96%	96%	97%	97%	96%
Horton Hospital	98%	99%	96%	96%	98%	98%	96%	97%	97%
John Radcliffe	94%	94%	94%	94%	94%	93%	92%	93%	94%
NOC	96%	96%	97%	97%	95%	96%	97%	97%	98%

Oversight of quality is undertaken at each OCCG Governing body meeting in public (held in common with Buckinghamshire and Berkshire West CCGs) and through the Oxfordshire Quality Committee. The Oxfordshire Quality Committee is chaired by the Medical Specialist Advisor from the OCCG Governing Body, includes Healthwatch Oxfordshire and a lay representative from the public and brings together local providers to review the agreed quality priorities, scrutinise and challenge each other to develop a shared learning forum and co-production principles for improving quality.

Safeguarding our most vulnerable

CCGs have a statutory duty to put in place appropriate arrangements to safeguard children and adults at risk. This includes:

- ensuring that the CCG's internal safeguarding arrangements are robust and that safeguarding is embedded in all practice;
- being assured that the safeguarding arrangements of all commissioned services are appropriate and providers are undertaking their duties with due diligence;
- co-operating with local safeguarding arrangements, as active partners;
- securing the expertise of Designated Professionals on behalf of the local health system to provide leadership throughout health and multi- agency partnerships.

Protecting children and adults at risk of abuse is a key focus within the CCG's approach to commissioning, together with a focus on safety, quality, and patient experience. Safeguarding within the CCG is underpinned by data and intelligence and, contracting systems and processes that will identify and quickly respond to any concerns, to achieve the aim of reducing the risk of harm.

In 2021/2022 partnership working has been enhanced though a number of joint initiatives including developing joint assurance processes, promoting awareness of domestic abuse in minority populations through co-production of training materials, maintaining regular support and supervision for primary care teams, developing joint safety planning for supporting those with complex care needs, creation of multi-agency protocols and ensuring lessons learnt from case reviews and audits are disseminated.

The CCG Safeguarding Team is located within the Quality and Nursing Team with the accountability for safeguarding being delegated from the CCG Accountable Officer to the Head of Quality who is supported by CCG's Safeguarding Designated Professionals. The CCG is a key partner of the Local

Safeguarding Board Partnerships, and an active core member in both adult and children's partnerships, through representation from the Head of Quality and the Designated Professionals.

Addressing health inequalities

Work continues across the BOB ICS to reduce health inequalities; in the past year a BOB- wide equalities group has been established to identify inequalities and implement evidence-based interventions to reduce the gaps by working with local communities and ensure learning is shared on best practice which makes a difference. The BOB Reducing Inequalities Board has agreed that coronary heart disease will be the priority, with a focus on hypertension case finding and management and stopping smoking as its main interventions.

The BOB Vaccine Equality Board was established in 2021/22, as part of the BOB Vaccination Programme to provide a focus on ways to increase vaccine confidence and ensure equitable access for people living in deprived and/or rural areas, diverse ethnic or vulnerable groups by working with big employers and community and voluntary groups. Please see the vaccination section for details and local initiatives.

NHS partners continue to work with local authority colleagues and voluntary organisations to return to business as usual and plan work for 2022/23 in line with government guidelines and the development of BOB as an Integrated Care System.

Some further examples are outlined below:

Gypsy, Romany and Travellers: OCCG worked with Margaret Clitherow Trust to reach young adults on both registered and unregistered sites in Oxfordshire.

Younger age groups in Chinese communities: materials were developed to encourage people to get vaccinated for the Chinese New Year. These were distributed through takeaways and restaurants across the county

Working with our community and faith leaders: Building on relationships built at the beginning of the pandemic OCCG carried on working with community and faith leaders to help encourage people to get vaccinated. Work included filming leaders having their vaccine and sharing positive messages about the vaccine; the films were made available in different languages. OCCG also created an animation to promote the benefits of getting a booster vaccination which were then translated into the top seven requested languages:

Supporting pregnancy women: OCCG worked closely with OUH to encourage pregnant women to get vaccinated by offering reassurance to women that they can have the COVID-19 vaccine while trying to get pregnant, are pregnant, or breastfeeding – and that it would not impact on their fertility. Dr Brenda Kelly a Consultant Obstetrician at OUHFT recorded a series of videos with information about what pregnant women should expect when considering the vaccine. These can be watched on YouTube.

Younger population: 'It's not too late' is a campaign that was run in early 2022 through all communication channels but with a particular focus on targeting digital radio advertisements to encourage people aged 18 to 39 that it is never too late to come forward to get either your first, second or booster vaccine.

Covid Community Champions: Oxford City and Reading are implementing plans for the development of COVID-19 Community Champions to work with communities on the ground to spread messages about COVID-19 vaccination and wider health and wellbeing. Oxford City is also leading multiagency work to vaccinate homeless people in the city supported by a local GP and PCN.

Maternity Champion: Work is underway to establish a Maternity Champion in Berkshire West, Buckinghamshire and Oxfordshire. They will be based in the local hospitals and engage with pregnant women onsite on COVID-19, flu and whooping cough vaccination to provide information and the offer of vaccination for those that would like it. They will also be offering carbon monoxide monitoring, Stop Smoking and other lifestyle advice.

Health on the move: As mentioned earlier in the report, the Health on the Move vans were used to outreach into different communities who were struggling to access the vaccine or were potentially vaccine-hesitant.

Engaging the public and local communities

The CCGs across BOB are committed to continuously strengthening public participation in all areas of work. However, progressing this during 2021/22 has been challenging. Understandably, the COVID-19 pandemic has been a major focus in the NHS and resources, including communications and engagement staff, were diverted to supporting frontline services in caring for patients. Information and guidance to support patients, the public and clinicians working across the local NHS needed to be refreshed, updated and communicated speedily. Despite this re-routing, some engagement work has been undertaken across BOB and at a local level.

A key feature and point of difference during the pandemic was accelerated delivery of remote and virtual services. As a clear step to reduce the spread of COVID-19, GP practices were required to introduce total triage. Patients were assessed by a GP over the phone or online first, allowing many people to be offered advice, prescriptions or referral without the need for a face-to-face appointment. For patients with the relevant technology, appointments have been available using video conferencing with healthcare professionals.

Part of this new way of working included the introduction of an online advice and appointment system. The form-based online consultation platform collects a patient's medical or administrative request and sends it through to their GP practice to triage and decide on the right care.

Across BOB, GP practices use various tools so patients can contact their GP. To get a better understanding of the patient experience and to inform a BOB-wide procurement process for an online consultation platform across the ICS, a survey was undertaken to seek feedback on what patients thought of these tools and how they help to manage their health. The survey was promoted through the three CCGs and focused on three tools:

- **Online Consultations**: Online consultation enables patients to contact their GP or other health professional by completing an online form or speaking to someone online about health concerns.
- **Video Consultations**: Some practices also now offer video consultation tools which allow patients to have a video appointment with a GP or healthcare professional.
- **Text messaging**: GP practices can send text messages to patients to communicate with them regarding care and inform them of things that are happening at the practice.

More than 1,000 survey responses were received across BOB and the feedback informed the procurement process for a BOB-wide system for primary care**.**

In Oxfordshire, like other areas of the country, the on-going need to protect patients and staff from infection meant that face-to-face methods of engaging patients and the public were suspended. This includes meetings in public which have moved online and require members of the public to have access to the internet to be able to participate. More information about the guidance OCCG follows, including the principles for engagement is available here.

While the pandemic has meant fewer engagement projects, there have been several initiatives to improve the accessibility of services for patients

across Oxfordshire.

Friends and Family Test: OUH led an online survey that was extended to the staff vaccine clinic. Potential respondents were encouraged to use their 15-minute observation period to complete the survey on their own smartphones, accessing it via a QR code prominently displayed in waiting areas.

1,895 service users responded to the survey and rated their experience as follows:

- Very good: 1614 (85.2%)
- Good: 227 (12.0%)
- Neither good nor poor: 30 (1.6%)
- Poor: 20 (1.1%)
- Very poor: 3 (~0.2%)
- Don't know: 1 (~0.1%)

Telephone and Video Consultation experience: Oxford Health launched a patient survey to understand patient and clinician experiences with telephone and video appointments in mental health care during the pandemic. This survey remains live into 2022.

CAMHS: In partnership with the Oxfordshire Parent Carer Forum, Oxford Health launched a survey to understand people's experience of services in the county. The survey was co-produced with parent carers and the results are currently under review.

Improving Community Health and Care services: Oxfordshire's health partners and councils are working together with voluntary and community sector groups to modernise community services. A period of public engagement took place in September and October 2021 around draft principles to help shape how to design and develop these services for the ageing population. Three public events were held, as well as meetings with the Oxfordshire 'Team-Up' Co-production Board and with the Age UK and the Voluntary Community Sector Coalition. Overall, there was recognition that care in the community and at home is best for elderly patients, but services must be joined up and provide accessible wrap around care. This work programme is continuing, with the appointed of a new programme director.

Special Education Needs & Disability Consultation: Across health, social care and education, Oxfordshire has been consulting on proposals around special educational needs (SEND) provision in the county. OCC and its partners have been seeking views on a draft Local Area SEND Strategy to develop high quality services across education, health, and social care to support children and young people and their families.

OCC's proposals for system reform for SEND include making more high-quality SEND education available closer to home, reducing reliance on out of county provision, and improving educational outcomes for children through closer partnerships between the council and schools. The consultation ended in March 2022 and results are currently under review.

Developing a sustainable environment

As part of the BOB ICS, OCCG is committed to delivering against the NHS Green Plan, which provides a focus on reducing the NHS's carbon footprint and delivering services more sustainably. This is an important part of the journey towards delivering the Greener NHS ambition of being the first healthcare system in the world to be net carbon zero. BOB ICS recognises that its sustainability journey will change ways of working which will allow for

a positive impact environmentally, socially and financially. In doing so, the ICS will be fit for the future and will support the long-term wellbeing of staff, patients and the wider communities it serves.

The ICS is made up of several different organisations to deliver a range of services which harness its ability to innovate and leverage the latest research and technology, to drive sustainability and individual and organisational behaviour change, across Buckinghamshire, Oxfordshire and Berkshire West. The Green Plan is part of the process of anchoring sustainability as key pillar in everything the ICS does.

The BOB ICS has already begun its green journey and is proud to have achieved the following:

- The development of provider estates strategies which has seen rationalisation and consolidation in the use of buildings
- The uptake in digital tools such as Microsoft Office 365 has enabled the adoption of highly agile ways of working across all teams and services. As well as telephone and video consultations in primary care, secondary care, mental health and community services which avoided thousands of miles of car journeys
- The removal of single use plastic cutlery and cups across all sites
- The roll out of carbon literacy training amongst senior level staff
- The increase in recycling bins amongst many of our sites

These initiatives not only have reduced the ICS's carbon footprint but have also prompted behaviour changes which is important in moving forward in our delivery of a net zero health service.

Responding to an emergency

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

- Co-operate and share relevant information with Category One responders
- Engage in cross-sector planning through Local Health Resilience Partnership
- Support NHS England (South East) in discharging its EPRR functions and duties locally
- Include relevant EPRR elements in contracts with providers
- Ensure that resilience is 'commissioned in' as part of standard provider contracts and to reflect risks identified through wider, multi-agency planning
- Reflect the need for providers to respond to routine operational pressures (e.g. Winter)
- Enable NHS funded providers to participate fully in EPRR exercises and testing programmes as part of the NHS England (South East) assurance process
- Provide commissioned providers with a route of escalation on a 24/7 basis if they fail to maintain their professional levels
- Respond to reasonable requests to assist and co-operate
- Support NHS England (South East) should any emergency require any NHS resources to be mobilised
- Support NHS England (South East) to effectively mobilise all applicable providers that support primary care services should the need arise.

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

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

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

Given the on-going response to the COVID-19 pandemic the past year has seen all NHS organisations and services operating, for the most part, in an EPRR level 4 incident which is means that NHS England coordinates the NHS response nationally in collaboration with local commissioners at the tactical level.

Due to the scale of the pandemic and the subsequent vaccination programme, NHS England determined that its response should be coordinated through Integrated Care Systems (ICS). The Buckingham Oxfordshire Berkshire West ICS (made up of the three CCGs and led by a single Accountable Officer) was able to develop and strengthen the response arrangements to increase resilience and effectiveness.

The first stage took place in October/November 2020 which involved all three CCGs releasing staff to support the BOB ICS Incident Infrastructure (for example deputy incident director), support for the Incident Coordination Centre rota and BOB-wide cells such as vaccination and supplies. This was strengthened during the second wave of the pandemic (January 2021) and has continued to operate at ICS level ever since.

NHS England has published NHS core standards for EPRR arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met.

As part of the national EPRR assurance process for 2021/22, Oxfordshire CCG has been required to assess itself against 24 core standards. The outcome of this self-assessment is that the CCG is substantially compliant with the standards with plans in place for the remaining three core standards. The overall rating is: Substantial.

How does OCCG manage its money?

The temporary financial regime implemented in 2020/21 continued into 2021/22. The block payment approach for NHS providers was extended in order to simplify payment arrangements and to ensure sufficient cash flow to providers to enable their response to the pandemic.

This was initially intended to cover the first six months of the year but was subsequently extended to the whole financial year. The CCG incurred a deficit of £1.0m in the first half of the year but was able to improve it's position in the second half and delivered a small surplus of £90k for the year as a whole.

OCCG brought forward a cumulative historic surplus of £23.4m into 2021/22 none of which was requested to be utilised (drawn down) in the year. The surplus achieved in 2021/22 will be added to the historic surplus and will be carried forward into next year.

For the financial year 2021/22, OCCG's total funding was £1,279.4m. Of this, £1,266.3m was allocated for healthcare programmes and £13.2m for the CCG's running costs as reflected in the table below which summarises our budget (plan) and actual expenditure for 2021/22:

	Budget Month 12 £'000	Actual Month 12 £'000	Variance Month 12 £'000
Allocation excluding historic surplus b fwd	**(1,278,175)**	**(1,278,175)**	**0**
Acute	652,146	651,790	(355)
Community Health	143,372	145,107	1,735
Continuing Care	67,368	74,220	6,852
Mental Health and Learning Disability	116,684	115,548	(1,136)
Delegated Co-Commissioning	113,777	114,947	1,170
Primary care	124,562	126,436	1,874
Other Programme	47,106	38,357	(8,749)
Sub Total Programme costs	**1,265,015**	**1,266,406**	**1,391**
Running costs	13,160	12,921	(239)
Total CCG Expenditure	**1,278,175**	**1,279,327**	**1,152**
Hospital Discharge Programme	628	0	(628)
Virtual Wards	543	0	(543)
Additional Roles Reimbursement Scheme	62	0	(62)
Vaccine Programme	10	0	(10)
Final allocation from NHS E	**1,243**	**0**	**(1,243)**
Total CCG after contributions to/from reserves	**1,279,418**	**1,279,327**	**(91)**
Historic surplus c fwd	23,441	0	(23,441)
Total CCG	**1,302,859**	**1,279,327**	**(23,532)**

OCCG has formal delegated responsibility from NHS England for GP Primary Care Commissioning and received an allocation of £113.8m in order to deliver this.

During the year OCCG spent £9.8m on COVID-19 related expenditure. The majority of this, £5.5m related to the Hospital Discharge Programme, £1.5m funded Primary care responses to the pandemic, £1.0m funded Long COVID, £0.5m for Virtual Wards and the £0.4m for the Vaccine Programme. This spend was reimbursed in full by NHSE.

It is a requirement of OCCG to meet the Mental Health Investment Standard (MHIS) each year whereby the investment into mental health services is at least in line with its overall increase in allocation. For 2021/22 the increase in mental health investment was 9.81% on the previous year which compares to the minimum increase required which was 4.33%. The MHIS achievement for 2021/22 will be subject to a separate audit at a later stage in the year.

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. The risk shares remained the same as for 2020/21. OCCG's contribution to the pooled budgets in 2021/22 was £200m while OCC contributed £204m.

In 2020/21, the County Council and the CCG developed a new HESC (Health Education and Social Care) model for joint commissioning. The new governance structure went live from April 2021 in the form of a new Joint Commissioning Executive (JCE). It was expected that a new Section 75 agreement would be enacted during 2021/22 but, whilst work has progressed in this area, it has been decided to extend the current agreement into 2022/23 until such time as the new ICB is assured around the financial implications.

In line with national policy direction for the NHS, OCCG continues to work closely with Buckinghamshire and Berkshire West CCGs as part of the wider BOB ICS. Organisations now work more closely together to make choices and decisions about how the Oxfordshire pound (£) is spent. Oxfordshire CCG has continued as the host organisation for the majority of funding from NHS England for BOB ICS in 2021/22. £120.7m was received on behalf of the ICS during the year and was passed on to the other CCGs or direct to providers as agreed. The ICB will become a statutory body on 1 July 2022. Until then, the three CCGs continue to deliver services for the first three months of the year.

For the next financial year 2022/23, BOB ICS has been issued with a financial envelope by NHS England based on national inflation and growth assumptions. In April 2022, the ICS submitted its final plans for the year having submitted draft plans in March 2022.

Constitutional Targets

As you will see from this report, the CCG works collaboratively with providers in the local health economy, in particular OUH (Acute and Elective Services), Oxford Health (Mental Health and Community Services), and South Central Ambulance Services NHS Foundation Trust (999, 111, and patient transport services) to deliver timely and robust healthcare provision. Meetings are held to provide assurance on actions being taken by providers to ensure performance achievement. Where performance is not achieved, we work together in partnership to resolve the issues and to develop remedial actions plans to recover performance.

NHS services in system have faced unprecedented pressures over the course of the pandemic waves and have responded to a significant increase in demand on Primary, Community and Acute services as well as delivering the biggest vaccination programme in history. During 2021/22 we have made use of the available technology to enable our meetings to continue and our actions have been weighted towards the system response to the pandemic.

The system has been under significant pressure during the increase in COVID-19 numbers associated during delta and more recently Omicron during the latter half of this year. This has been compounded by high level of demand during the winter months. System providers have generally maintained planned treatment during Omicron and are working to reduce the significant wait times and backlogs generated during previous waves. To support NHS Trusts' capacity for urgent care, Independent Sector Provider (ISPs) sites were directed by NHSE under a national contractual and financial arrangement to assist all regions and protect capacity for elective services (including cancer).

The table below outlines the NHS constitutional targets that NHS Oxfordshire CCG has a duty to meet.

Group	Standard Description	Standard	Year end 2021/22
Cancer	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	93%	76.6%
	Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected	93%	35.0%
	Percentage of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat')	96%	91.4%
	Percentage of patients receiving first subsequent treatment within 31-day, where that treatment is Surgery	98%	79.5%
	Percentage of patients receiving first subsequent treatment within 31-day, where that treatment is an Anti-Cancer Drug Regimen	94%	98.6%
	Percentage of patients receiving first subsequent treatment within 31-day, where that treatment is a Radiotherapy Treatment Course	94%	89.1%
	Percentage of patients receiving first definitive treatment within two months (62 days) of an urgent GP referral for suspected cancer	85%	75.3%
	Percentage of patients receiving first definitive treatment within 62 days of referral from NHS Screening Service	90%	71.4%
	Percentage of patients receiving first definitive treatment within 62 days of a consultants decision to upgrade their priority status	86%	68.3%
RTT - Incomplete	Incomplete pathways at month end	92%	70.6%
	Incomplete Pathways over 52 weeks at month end	0	1,173
Mental Health	IAPT - Access Rate	6.25%	5.199%
	IAPT - Moving to Recovery	50%	48.9%
	IAPT - Treated within 6 Week	75%	99.3%

	IAPT - Treated within 18 Week	95%	100.0%
	Dementia Diagnosis Rate	67%	61.1%
C&YP Eating Disorders	CYP Eating Disorders - Urgent (1 week)	95%	56.3%
	CYP Eating Disorders - Routine (4 weeks)	95%	27.2%
Ambulance Response Times	Category 1 Incidents Mean	7:00	10:57
	Category 1 Incidents 90th Percentile	15:00	21:19
	Category 2 Incidents Mean	18:00	39:44
	Category 2 Incidents 90th Percentile	40:00	81:29
	Category 3 Incidents 90th Percentile	120:00	394:25
	Category 4 Incidents 90th Percentile	180:00	410:17

How does OCCG monitor performance?

The OCCG Governing Body is responsible for discharging the duties of its constitution, which includes monitoring and scrutinising the performance of service providers. The Governing Body receives an integrated performance report at the quarterly meetings in public. Formal committees of the Governing Body 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 48). 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. Over 2021/22 the OCCG Governing Body and Committees met in in common with those of Buckinghamshire and Berkshire West CCGs. This has enabled us to develop joint reporting and receive a different perspective on the topics discussed.

How is OCCG monitored?

NHS England has a statutory duty to undertake annual assessment of CCGs. This is undertaken using the NHS System Oversight Framework 2021/22. The framework is intended as a focal point for joint work, support and dialogue between NHS England, NHS Improvement, CCGs, providers and integrated care systems. The NHS providers and CCGs in the BOB ICS are currently in segment 3 (1-4 segments). This means the BOB ICS is working with NHSE/I regional teams work to undertake a diagnostic stocktake to identify the key drivers of the concerns that need to be resolved and then improvement actions are agreed.

Managing risk

Reducing risk across the health system is a priority for OCCG to ensure patients receive high standards of care. Risks are events or scenarios which can hamper OCCG's ability to achieve its objectives. These risks, divided into strategic and operational, are identified, assessed and managed by the organisation and reviewed at every OCCG Governing Body meeting in public. They are continually reviewed at Governing Body committee meetings including the Audit Committee, the Finance Committee, the Oxfordshire Primary Care Commissioning Committee, the Oxfordshire Quality Committee and the OCCG Executive Committee. The report on OCCG's principal, strategic and operational risks and mitigations as of 31 March 2022 can be found on OCCG's website here.

The year ahead

Through the first three months of 2022/23 OCCG will remain the statutory organisation for commissioning health services in Oxfordshire. We will use these months to continue to prepare for organisational change with the close of OCCG and the safe transfer of CCG functions and staff into the new BOB ICB.

As we move to become an ICB we will at the same time develop our integrated care system (ICS) which will aim to deliver health and social care to people in a more joined up way across local councils, the NHS, voluntary organisations and other partners. The ICS will be a new partnership of health and care organisations across BOB that will plan and deliver joined up services and improve the health and wellbeing of people who live and work in the area. The four main goals of the ICS are to

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

While these were all set out as goals in the Long Term Plan and are not new, how we organise ourselves across health and care is changing. We hope with the development of BOB ICS, where traditional barriers may have existed between different parts of the NHS, between physical and mental health and between the NHS and local authorities, these will be removed, and care will be delivered in a more seamless way with better outcomes for our patients.

Much work has already been undertaken to transfer from three CCGs to the new ICB; an interim executive team is in place and recruitment for permanent leaders for the new organisation to develop the ICS is well underway. Work is continuing to develop better relationships across health and care and develop a BOB ICS System Development Plan to further our work. NHS Chief Executives and senior leaders from across the system have agreed three operational services areas of priority for the next six to 12 months. There will be a focus on:

- Planned / elective care (which includes elective recovery as we make our way out of the pandemic)
- Children and adolescent mental health services
- Urgent and emergency care

These areas are considerably challenged across all three places, indeed nationally, and would benefit from working better together across the ICS. Capacity has been increased and there is dedicated resource working with place leads across the ICS reviewing and working to improve the most challenged pathways. For example, in elective care the BOB work is focused on ENT and ophthalmology.

As we progress into 2022/23 the ICS will develop a comprehensive strategy to identify the medium- and long-term priorities for the system with clearly defined outcomes and resourced programmes to deliver our ambitions. This will be done in partnership with our stakeholders and local communities within each place across BOB.

For most people, their day-to day care and support needs will be met locally in the place where they live; the way patients access services will not change.

Dr James Kent
Accountable Officer
21 June 2022

Accountability Report

Corporate Governance Report

Members Report

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

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

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

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

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

South: The South Network Area is made up of 22 practices covering the registered population. Dr Ed Capo Bianco covered the role of South Network Clinical Director alongside his role as Urgent & Emergency Care Portfolio Director.

1. Abingdon Surgery
2. Berinsfield Health Centre
3. Chalgrove and Watlington Surgeries
4. Church Street Practice
5. Clifton Hampden Surgery
6. Didcot Health Centre
7. Goring and Woodcote
8. Long Furlong Surgery
9. Malthouse Surgery
10. Marcham Road Surgery

11. Mill Stream Surgery
12. Morland House Surgery
13. Nettlebed Surgery
14. Newbury Street Practice
15. Oak Tree Health Centre
16. Sonning Common Health Centre
17. The Bell Surgery
18. The Hart Surgery
19. The Rycote Practice
20. Wallingford Medical Practice
21. White Horse Surgery
22. Woodlands Medical Centre

Members of the Governing Body

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

- Dr David Chapman, Clinical Chair, OCCG
- Dr James Kent, Accountable Officer, OCCG and Executive Lead for the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care System

Along with the Accountable Officer and Clinical Chair, the Governing Body 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 of 31 March 2022 includes:

- Ansaf Azhar, Corporate Director of Public Health, OCC
- Dr Ed Capo-Bianco, Urgent & Emergency Care Portfolio Clinical Director
- Wendy Bower, Lay member, PPI - (Appointed 10 June 2021)
- Stephen Chandler, Corporate Director Adults and Housing at OCC
- Dr David Chapman, Clinical Chair
- Jo Cogswell, Director of Transformation
- Heidi Devenish, Practice Manager Representative
- Dr Sam Hart, North Network Clinical Director
- Dr Shelley Hayles, Planned Care Portfolio Clinical Director (retired 31 March 2022)
- Diane Hedges, Deputy Chief Executive
- Gareth Kenworthy, Director of Finance
- Catherine Mountford, Director of Governance

- Dr Meenu Paul, Clinical Lead, Mental Health, Learning Disability – (Appointed 1 September 2021)
- Robert Parkes, Lay Vice Chair/Chair of Audit Committee – (Appointed 9 September 2021)
- Dr Guy Rooney, Specialist Medical Advisor
- Duncan Smith, Lay Member for Finance
- Dr Andy Valentine, Oxford City Network Clinical Director
- Sula Wiltshire, OCCG Board Nurse (term ended 31 March 2022)

The following people were members of the Governing Body during 2021/2022 but were not in post as of 31 March 2022:

- Dr Kiren Collison, GP Clinical Lead (Chair) (Left July 2021)
- Roger Dickinson, Lay Vice Chair and Lay Member (Left - 10 June 2021)

Profiles of OCCG Clinical Leads

Dr Ed Capo-Bianco

Urgent and Emergency Care Portfolio Clinical Director

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

Within my urgent care role, I've worked with OUH paediatricians and OH community childrens nursing team to develop an ambulatory children's model, in response to the impending RSV (Respiratory Syncitial Virus) surge. We held webinars for GPs, procured paediatric oxygen saturation monitors appropriate for under 2-year-olds for every GP practice in Oxfordshire and have expanded the service to include gastroenteritis and other conditions will follow, now that the next year of funding is secured.

We developed some new initiatives over winter, to reduce the need for hospital attendances or improve the speed to discharge patients home. The children's ambulatory model was one; others included an extension to the settling in service where SCAS paramedics assist in taking patients back home from A&E; extending the working hours of pharmacists on the emergency admission unit enabling swifter discharges and reducing pressure on the on-call pharmacist at OUH.

As part of my cardiovascular work, we have continued to develop the blood pressure at home model, expanding to include 57 out of 67 practices in Oxfordshire, with over 3000 blood pressure monitors delivered to practices to give out to patients. We have also been working closely with heart failure colleagues to try and further develop their service.

In my end of life care work, we have successfully opened 2 palliative care beds in South Oxfordshire at Wallingford Community Hospital, in partnership with Oxford Health and Sue Ryder. Recent data shows these beds are being well utilised and offering a good service to patients for either end of life care or symptom management.

During the year we have launched a project (EARLY) in partnership with OUH to train clinicians in general practice other than GPs to be signatories on DNACPR (Do Not Attempt Cardio-Pulmonary Resuscitation) documents and to have advanced care planning

conversations. This should take some of the pressure off GPs being the only ones in a practice being able to do this work. I have also been involved in the workstream to develop a countywide hospice at home service under the care of the Sobell House team, called RIPEL (Rapid Intervention for Palliative and End of Life care). This service will provide responsive care to patients in their own home in their final days or weeks of life, reducing the need for emergency hospital attendances or being able to get home more quickly.

Greater collaboration across the BOB ICS, has meant a number of meetings involving clinicians and specialties across the 3 counties, particularly with the CVD work.

Boards and committees:

- Oxfordshire Clinical Commissioning Group Governing Body
- OCCG Executive Committee
- Finance Committee
- Joint Commissioning Executive (between OCC and OCCG)
- Area Prescribing Committee Oxfordshire (APCO)

Dr Sam Hart

North Network Clinical Director

As North Network Clinical Director, I have chaired Member Practice Commissioning Forum Meetings for the North sub-place geography as the CCG mechanisms for engagement with member practices evolve in the transition towards working as an ICS/ICB. Plans for how the primary care voice is heard within the new system have been developed gradually throughout 2021 into 2022 with support of the LMC, which are yet to be fully realised as the transition continues – I have contributed to this process and I remain committed to ensuring that primary care has visibility and influence within Oxfordshire and the ICB.

We are emerging from COVID-19 but there remains much work to be done. The Primary Care COVID-19 Oximetry at Home service (PCCO@h) continues under my leadership and it has facilitated over 1500 patients being monitored at home via their GP. With increasing interest in Virtual Wards, lessons from this project have begun to inform how we can do more to care for people at home. The biggest task at hand is recovery after COVID-19 and I have been involved in many meetings trying to shape the development of community services with key stakeholders, to get best for the whole system and to engender co-operative working aligned to ICB principles. Consequently, I've led on OCCG offering facilitated recruitment of a Care Co-Ordinator role to PCNs, as a tangible means of improving integrated working.

I continue to perform my OCCG roles at board and clinical executive meetings, and I chair Oxfordshire Primary Care Committee Operation Group.

I have also been involved in a lengthy and detailed MSK procurement process, and I am now assisting in the implementation phase prior to the new provider commencing in October 2022.

Boards and committees:

- Oxfordshire Clinical Commissioning Group Governing Body
- OCCG Executive Committee

Dr Shelley Hayles

Planned Care Portfolio Clinical Director

My clinical director role this year has been very different in planned care and cancer. Nothing was 'planned' about COVID-19. The planned care team has worked on establishing the information needed to maintain as much business as usual, by prioritising certain pathways and straight to test, liaising with the Thames Valley Cancer Alliance to keep cancer referrals and services on track in those areas that have been most affected by the pandemic.

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

My primary care role within the TVCA has been to advise on the clinical priorities and to liaise carefully with our providers around their activity at such a difficult time. As the RDC TVCA primary care lead I have also been heavily involved in continuing to establish this service, despite the waves of COVID-19, as it is designed to alleviate unnecessary use of our scarce resources and builds heavily on the success of the Oxford SCAN pathway.

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

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

Boards and Committees:

- Oxfordshire Clinical Commissioning Group Governing Body
- OCCG Executive Committee

Other Networks:

- Thames Valley Cancer Alliance

Dr Meenu Paul

Assistant Clinical Director for Quality OCCG, Clinical Lead for Medicines Optimisation OCCG, Clinical Lead for Mental Health OCCG

Quality Role: In the last 12 months I have worked with colleagues to improve the quality in Primary Care in Oxfordshire. Areas of work include supporting GP practices before and after CQC inspections, chronic disease management, incident reviews , delivery of influenza vaccination and actions relating to the COVID-19 pandemic. There is always a focus on reducing inequalities and ensuring good access to GP services for all. This work involves good collaboration with many stakeholders in health and social care. Listening to the voice of people who use these services is an important part of this work. I also work with colleagues at Oxford Health analysing serious incidents and developing action plans for quality improvement.

Medicines Optimisation Role: In the last 12 months I have been working with colleagues on prescribing guidelines, safe prescribing and implementation of NICE guidance. I chair the Oxfordshire Area Prescribing Committee which is attended by CCG, Secondary Care and also Community Pharmacy colleagues. Formulary decisions are made here on a wide variety of medications.

Mental Health Role: I have been working with colleagues to improve the care and support people with learning disability and /or severe mental illness. Focus has been on improving the rates of annual reviews and blood tests in the last 12 months. There has been work on improving the IT systems between GP practices and Oxford Health so that a patient's care is more joined up. The aim is for a higher standard of care for those using these services.

Boards and committees:

- Oxfordshire Clinical Commissioning Group Governing Body
- OCCG Executive Committee
- Joint Governing Bodies Committee
- Primary Care Commissioning Committee
- COVID-19 Health Protection Board
- Oxfordshire Joint Infection Control Committee
- Chair of Area Prescribing Committee Oxfordshire

Dr Andrew Valentine

City Network Clinical Director & Clinical Director of Quality

Over the last 12 months I have worked in OCCG roles as Clinical Director of Quality and Oxford City Network Clinical Director.

I work with healthcare providers regarding Quality issues, for example reviewing serious incidents, and developing safer cancer referral pathways.

In my role as Network Clinical Director, I have contributed to ICB board and clinical executive meetings. I have worked with the Community Nursing service to better understand pressures in the community, and to develop plans to ensure safe care. Liaison with Primary Care colleagues has been important as we migrate to a new commissioning framework and need to develop clinical leadership and representation.

Boards and committees:

- Oxfordshire Clinical Commissioning Group Governing Body

- OCCG Executive Committee
- Joint Governing Bodies Committee

Other clinical leads working with OCCG include:

- Dr Mary Akinola (Individual Funding Request Clinical Lead)
- Dr Amar Latif (Long Term Conditions Clinical Lead)
- Dr Meriel Raine (Safeguarding Clinical Lead)
- Dr Sue Ruddock (Area Prescribing Committee Oxfordshire Clinical Lead)
- Dr Nick Thomas (Individual Funding Request Clinical Lead)

Statement of Disclosure to Auditors

Everyone who is a member of the Board at 31 March 2022 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 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 47 for information about the committees of the Board including membership and attendance.

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

Personal Data Related Incidents

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

Modern Slavery Act

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

Statement of Accountable Officer's Responsibilities

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

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

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

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

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

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

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

Dr James Kent
Accountable Officer
21 June 2022

Annual Governance Statement

Introduction and context

Oxfordshire CCG 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 required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As of 1 April 2022, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

The CCG Constitution sets out how the organisation will work with and on behalf of the local clinical community to enhance the health and wellbeing of its local population, and how it will fulfil its statutory duties. The CCG has the following statutory committees:

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

It has also established:

- Finance Committee
- Executive Committee
- Quality Committee

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

Standing Orders regulate the proceedings of the CCG, as set out in the Health and Social Care Act 2012 ("HSCA"). The Standing Orders, together with the CCG's scheme of delegation and the CCG's prime financial policies, provide the procedural framework within which the CCG discharges its business.

COVID-19 Pandemic

During the whole of 2021/22 the NHS has been responding to the COVID-19 pandemic. This has included operating at level 4 (national control) or Level 3 (regional control) for most of the year. This required some amendment to the way the CCG operated including the following:

- Implementation of COVID-19 specific and temporary framework of meetings, an extension of those agreed in 2020/21.
- Governing Body and Primary Care Commissioning Committees were held virtually as meetings in public with attendees able to submit questions.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

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

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

Governing Body

To align process across the three CCGs and in accordance with the Buckinghamshire, Oxfordshire, and Berkshire West (BOB) CCGs Constitutions, the BOB CCGs Governing Bodies held their meetings 'in common' during 2021/22, holding five meetings in public during this period. The meetings that were due to be held in December 2021 were postponed due to the need to concentrate on the NHS response to COVID-19; these meetings subsequently took place in January 2022.

All meetings were quorate in terms of executive and lay member representation. Where meetings were not quorate, in terms of GP clinical representation, matters that required approval were obtained virtually. A table of members attendance is included in Appendix 1.

Matters Reserved to the Membership Body (Practice Members) are clearly defined in the CCGs Constitution.

The Practice Members are represented on the Governing Body through the Area Network and Portfolio Clinical Directors.,

The Governing Bodies in 2021/22 focused on organisational objectives, national priorities, and the local health economy's priorities in the Operational Plan. The Board has also held workshops on 'Constitutional alignment across the BOB CCGs'.

Standing agenda items include the Accountable Officers' report, items in relation to finance, strategic risk, corporate governance, performance, patient and public involvement, and clinical concerns. Other items discussed this year include:

- Budget setting and arrangements for annual report and accounts
- Ratification of policies and procedures as required
- NHS Priorities and Operational Planning
- Governance Alignment
- Developing the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care System (ICS)
- Future provision for GP IT
- Operational Priority Service – Urgent and Emergency Care
- Communications, Patient and Public Community Engagement
- Emergency Preparedness Response and Resilience (EPRR) winter preparedness and Annual Report
- Response to and recovery from COVID-19, including governance accountability and compliance with statutory duties

The Governing Bodies also reviewed their own governance arrangements and effectiveness. Members' attendance, apologies for absence, and declarations of interests and/or conflicts of interests (including gifts, hospitality) were formally recorded and published in the minutes of the meetings.

Governing Body Committees

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

Audit Committee

As for the Governing Bodies, the BOB CCG Audit Committees held their meetings 'in common'. The Committee reviews critically the CCG's financial reporting and internal control principles; ensures that all the CCG's activities are managed in accordance with legislation and regulations governing the NHS; ensures adequate assurance is in place over the management of significant risks; and ensures that appropriate relationships with both internal and external auditors are maintained. The Audit Committees met four times in 2021/22.

The Audit Committees 'in common' receive regular reports to provide it with assurance from:

- The Directors of Finance and deputies on finances and performance, losses and special payments and single tender waivers
- Internal Audit and External Audit – including reports on the outcome of reviews together with recommendations on any necessary actions
- The Local Counter Fraud Specialists (LCFS)
- The Directors of Finance and Governance in respect of the Strategic and Operational risk registers
- The Director of Governance in respect of corporate governance including conflicts of interest exceptions, gifts, hospitality, sponsorship, joint working agreements.
- The Senior Information Risk Owner (SIRO) in respect of data security and protection arrangements.

The Accountable (Chief) Officer and other executive directors attend meetings as requested. Representatives of internal audit, external audit and local counter fraud service attend each meeting. A meeting in private session with the Lay Members is also held at least once per annum. The agenda of the Audit Committee is governed by its annual business cycle. A table of members attendance is included in Appendix 1.

Remuneration Committee

As for the Governing Bodies and Audit Committees, the Remuneration Committees held their meetings 'in common'. This Committee reviews the framework for the Remuneration, Allowances and Terms of Service for employees of the CCG and for people who provide services to the CCG. It makes recommendations to ensure effective oversight of the performance of the CCG's Accountable Officer, Directors of Finance, and other senior posts, and for scrutiny of any redundancy payments. The Remuneration committees met three times in 2021/22.

The overall purpose of the Remuneration Committee is to assure the Governing Bodies that the duty to act effectively, efficiently, and economically has been met, and that use of resources for remuneration does not exceed any amount specified. A table of members attendance is included in Appendix 1.

Primary Care Commissioning Committee (PCCC)

The BW CCG Primary Care Commissioning Committee held its individual (at Place) meeting in April 2021(Q1 April- June) before moving to an in-common BOB CCGs PCCC, meeting (Q2-4 July – March). The PCCC Committee has been established in accordance with the statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Buckinghamshire, Oxfordshire, and Berkshire West under delegated authority from NHS England.

Meetings are held four times a year and in public. Health and Wellbeing Board representatives and NHS England are also invited to attend in accordance with the Delegation Agreement. The CCG's clinical leads are voting members.

The Committee met three times in 2021/2022 as one meeting was stood down due to the requirement to support the national response to the COVID-19 pandemic.

The Committee undertakes the following activities:

- Review and monitor GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, taking contractual action such as issuing breach/remedial notices, and removing a contract) and enhanced services ("Local Commissioned Services" and "Directed Enhanced Services")
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF)
- Decision making on whether to establish new GP practices in an area and to approve practice mergers and making decisions on 'discretionary' payments
- To plan, including needs assessment, primary care services across BOB and undertakes and delivers a primary care estates strategy across the BOB geography
- To undertake reviews and manage the budget for commissioning of primary care services at Place and to co-ordinate a common approach to the commissioning of primary care services generally
- To assist and support NHS England in discharging its duty under section13E of the NHS Act 2006 (as amended by the Health and Social Care Act2012) so far as relating to securing continuous improvement in the quality of primary medical services.

A table of members attendance is included in Appendix 1.

Executive Committee

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

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

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

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

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

Finance Committee

As with the Governing Bodies delegated Committees, and to align services across BOB, the Finance Committees held their meetings ‘in common’ during 2021/22. The Finance Committee scrutinises the financial plans and performance in relation to key national targets and in support of the delivery of the outcomes included in the NHS Long Term Plan. It also takes relevant decisions as required under delegated authority, such as business cases.

The Committee reviews reports, identifying key issues and risks and gives opinion and assurance to Governing Body on the stewardship of CCG financial resources and their going concern status. Additionally, the Governing Body may request that the Finance Committee reviews specific aspects of financial performance where they require additional scrutiny and assurance. The Committee met nine times in 2021/22.

A table of members attendance is included in Appendix 1.

The work of the Committee also includes the following activities:

- Monitor use of financial resources and to ensure that value for money can be demonstrated and that the best possible value is secured for the

BOB pound

- Scrutiny of Quality, Innovation, Productivity and Prevention (QIPP) and Cost Improvement Programmes (CIPs)
- Evaluate, scrutinise and quality assure the financial validity of the investment, disinvestment, and business case framework.
- Maintain an overview of the value for money provided by the CCGs' expenditure, contracts, and support arrangements (for example, the contract provided by NHS South, Central and West Commissioning Support Unit)
- Approves the release of finance from allocated reserves to support investments and to make recommendations to the Governing Bodies as appropriate.
- Advise the Governing Bodies on relevant reports by NHS England, regulators and other national bodies, and, where appropriate, management's response to these.

Quality Committee

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

It promotes a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness, outcomes, and patient experience. This includes a responsibility to promote research and the use of research and monitor reports made to the National Reporting and Learning System.

The Committee met 3 times in 2021/22. A table of members attendance is included in Appendix 1.

The work of the Committee also includes the following activities:

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

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on our governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code considered relevant to the clinical commissioning groups and best practice. The Corporate Governance Report is intended to demonstrate the clinical commissioning groups' compliance with the principles as set out in the Code.

For the financial year ending 31 March 2022 and up to the signing of the statements, we complied with the provisions set out in the Code and applied the principles of the Code.

Discharge of Statutory Functions

Considering the recommendations of the 1983 Harris Review, The Clinical Commissioning Group has reviewed all the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations.

As a result, I, the Accountable Officer, can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

Risk management arrangements and effectiveness

The Audit Committees, at their meetings in common, review the full Strategic Risk Register at [4]every meeting; the Quality Committees review and discusses risks relating to quality and performance; the Finance Committees, at their meetings in common, review and discuss financial risks; Primary Care Commissioning Committee's review and discusses Primary Care risks.

Capacity to Handle Risk

The Governance Team co-ordinate production of risk registers, offer advice and training (when required) and work with designated risk owners and Executive Directors via individual meetings or designated Executive/Director meetings. The purpose of the meetings is to identify any new risk areas; ensuring the appropriate management, quality of recording and scoring of that risk; the review of all current risks obtaining assurance that appropriate actions and mitigations are in place and that all risks are reviewed and managed appropriately. The Governance Lead also maintains the risks cycle ensuring that timely reminders are sent to risks managers for each risk cycle as per Governing Body and Committee meetings.

Risk Assessment

Proposed new risks are presented as drafts to the Executive directors for approval ahead of inclusion on the risk register. Strategic risks are only closed with approval from the Executive and the Governing Body. 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 Governing Body.

[4] During the covid-19 pandemic and the requirement to assist in the rollout of the vaccination programme, the order and/or regularity of business being conducted at Audit Committee will have impacted on delivery of 'business as usual'.

CCG staff are responsible for maintaining risk awareness, identifying 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.

The BOB CCGs have 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 in place to support innovation and maximise opportunities to improve its service. The Audit committees will review the appetite statement on an annual basis and propose any changes to its Governing Bodies.

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.

The revised statutory guidance (further updated in June 2017) provides for a practical toolkit, which includes templates and case studies to support CCGs with conflicts of interest management. The CCG also takes guidance and assurance from the managing conflicts of interest in the NHS – guidance for staff and organisations (published June 2017) applicable to CCGs, NHS Trusts and NHS Foundation Trusts and NHS England.

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

The CCGs internal auditors carried out their annual audit for 2021/22 and made the following assessments/recommendations:

Oxfordshire CCG: Rated: ‘reasonable assurance’. Two low priority and one medium actions recommendation (a clear and consistent set of staff groups to be identified for each of the three conflicts of interest training modules; the standards of Business Conduct Policy should be updated to include Local Counter Fraud Service recommendations; and management of an undisclosed interest for one individual should be investigated).

- The first two actions will be picked up as part of the work for the new Integrated Care Board.
- The undisclosed interest was investigated and found to be immaterial

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 the three CCGs, and we continue to capitalise on strong relationships between NHS South Central and West Commissioning Support Unit (SCWCSU) and information governance teams within provider organisations to drive continuous improvement.

Information Governance

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

The CCG is due to submit its Data Security and Protection Toolkit for 2021/22 by the 30 June 2022. The date for submission was extended by NHS England due to the pressure on organisations caused by the COVID-19 pandemic.

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

There are established processes in place for incident reporting and investigation of serious incidents. In 2021/22, there were no incidents which required reporting to the information Commissioner's Office.

Information Governance is reported to the Audit Committees in common as a standing agenda item at each meeting and is reviewed regularly through BOB CCGs Information Governance Steering Group.

Business Critical Models

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

Third party assurances

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

Control Issues

The CCG's performance against constitutional targets has been impacted by the COVID-19 pandemic and further details can be found in the Performance Report along with information about how performance will be recovered through the course of 2021/22.

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

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

The Audit Committees met regularly throughout the 2021/22 financial year to review and monitor the CCGs' financial reporting and internal control principles; to ensure that the CCGs activities were managed in accordance with legislation and regulations governing the NHS; and to ensure that appropriate relationships were maintained with internal and external auditors.

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

The CCG has processes in place to secure economy, efficiency and effectiveness through its procurement, contract negotiation and contract management processes. Effectiveness is monitored specifically through the quality processes and Quality Committee.

The Director of Finance meets regularly with the CCG's finance teams and holds monthly meetings with the CSUs finance leads to review month-end reporting. Regular meetings are also held with the local authorities' finance leads.

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

The Financial regime

The financial regime put in place by NHSE for 2021/22 followed that which was in place for 2020/21 and fell into two halves – H1 and H2, the Finance and contracting arrangements for the six-month period from 1 April 2021 to 30 September 2021 ('H1 2021/22' or 'H1') and October 2021 to March 2022 (H2 2021/22 or H2).

The H1 arrangements

The funding was based on a System funding envelope, comprising of adjusted CCG allocations based on the H2 2020/21 envelopes adjusted for known pressures and policy priorities. The payment arrangements for NHS providers remained on a block payment arrangement but amended to reflect the changes to system funding envelopes, e.g., application of inflation and distribution of additional funding e.g., top up, COVID-19 funding. Signed contracts with NHS providers were not required. The commissioning of services from acute independent sector (IS) services returned to the CCG which were covered by the national IS contract during 2020/21.

The H1 being based on the 20/21 budgets with proposed uplifts from NHSE and extra ordinary expenditure covering COVID-19, and Hospital Discharge Programmes up to six weeks funded by a retrospective allocation to bring the CCG's back to a balanced position.

Through the H1 financial regime, systems had access to the following additional growth funding:

i. acute services – access to additional funding through the Elective Recovery Fund
ii. mental health services – additional CCG programme funding and service development funding (SDF) to enable delivery of the Mental Health Investment Standard (MHIS) and Long-Term Plan (LTP) priorities
iii. primary medical care services – additional primary care growth issued in line with the 2021/22 published CCG primary medical care
iv. community services – funding for demographic growth has been included within system funding envelopes. Access to additional non-demographic growth will be available through SDF for transforming community services, including for accelerating the rollout of the two-hour crisis community health response at home.

The H2 arrangements

For the H2 period the budget was based on the H1 funding envelope with additional uplifts applied as notified by NHSE to tariff and pay inflation. Payment arrangements continued, the funding for Hospital Discharge period moved from 6 weeks to 4 weeks, COVID-19 and other system funding to Providers maintained with the view that organisations will achieve a breakeven position.

For 2022/23 the System has been issued a Financial Envelope which includes growth funding but reductions in system support and COVID-19 funding with a view that the financial performance returns to a sustainable position.

Delegation of functions

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

The BOB Governing Bodies receive reports from each of their committees detailing the delivery of work, and associated risks, within their specific remit. Additionally, the Governing Bodies maintains a high-level overview of the organisations' business and identifies and assesses risks and issues straddling Committees. These risks are owned and overseen at Governing Body level and scrutinised at each meeting to ensure appropriate management and reporting is in place.

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

Counter fraud arrangements

The CCG is committed to reducing the risk from fraud and corruption and discharges its counter fraud responsibilities locally through its appointed Local Counter Fraud Specialist (LCFS) who acts as the "first line of defence" against fraud, bribery, and corruption, working closely with the CCG and NHSCFA. The Director of Finance is the Executive Lead for Counter Fraud. The CCG has a Counter Fraud and Corruption Policy and Response Plan in place, and this was last reviewed in January 2022.

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

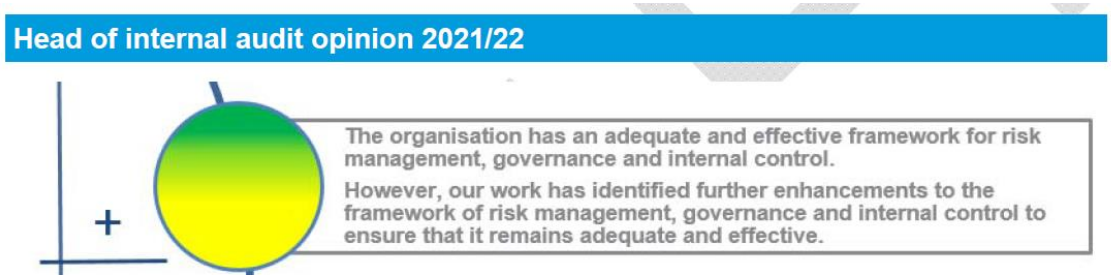
The CCG also participates in the National Fraud Initiative Exercise now run by the Cabinet Office which is a mandatory exercise that matched electronic data within and between public and private sector bodies to prevent and detect fraud. It has been run every two years since 1996.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the Clinical Commissioning Group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance, and internal control. The Head of Internal Audit concluded that:

In accordance with 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 month ended 31 March 2022, the draft head of internal audit opinion for OCCG is as follows:



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

Audit Area	**Oxfordshire CCG Assurance Level**
Delegated Commissioning	Substantial
Commissioning and Contract Management	Substantial
Financial Planning & Forecasting	Substantial
Conflicts of Interest	Reasonable
Risk Management	Partial
CCG Close Down and ICB Establishment Due Diligence Checklist – HR Deep Dive (Draft)	Reasonable

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

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

The strategic risk register itself provides me with evidence of the effectiveness of controls that manage risks to the clinical commissioning groups achieving its principal 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
21 June 2022

Renumeration 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 60.

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) 2021/22

Name	Title	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100*	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5 £000	All Pension Related Benefits (Bands of £2,500) £000	TOTAL (Bands of £5,000) £000
Ed Capo-Bianco	Urgent & Emergency Care Portfolio Clinical Director	65-70	0	0-5	0-5	15-17.5	80-85
David Chapman	Clinical Chair from 19.7.2021 (formerly Mental Health Portfolio Clinical Director)	80-85	0	0-5	0-5	0-2.5	80-85
Kiren Collison	Clinical Chair to 18.7.2021	5-10	0	0-5	0-5	17.5-20	25-30
Joanne Cogswell	Director of Transformation	115-120	6	0-5	0-5	25-27.5	140-145
Heidi Devenish	Practice Manager Representative	0-5	0	0-5	0-5	20-22.5	20-25
Shelley Hayles	Planned Care Portfolio Clinical Director	80-85	0	0-5	0-5	0-2.5	80-85
Diane Hedges	Chief Operating Officer and Deputy Chief Executive	120-125	0	0-5	0-5	30-32.5	150-155
Gareth Kenworthy	Director of Finance	120-125	0	0-5	0-5	32.5-35	155-160
James Kent	Accountable Officer	70-75	0	5-10	0-5	47.5-50	120-125
Catherine Mountford	Director of Governance	110-115	0	0-5	0-5	30-32.5	140-145
Guy Rooney	Medical Specialist Advisor	10-15	0	0-5	0-5	0-2.5	10-15
Ursula Wiltshire	Board Nurse	5-10	0	0-5	0-5	0-2.5	5-10
Sam Hart	North Network Clinical Director	45-50	36	0-5	0-5	0-2.5	45-50
Andy Valentine	Oxford City Network Clinical Director	45-50	0	0-5	0-5	30-32.5	75-80
Meenu Paul	Clinical Lead, Mental Health/Learning Disabilities from 1.9.2021	45-50	0	0-5	0-5	17.5-20	60-65
Non Executive Board							
Roger Dickinson	Independent Lay Member, Lead for Governance and Vice Chair to 30.6.2021	5-10	0	0-5	0-5	0-2.5	5-10
Duncan Smith	Independent Lay Member, Lead for Finance	15-20	0	0-5	0-5	0-2.5	15-20
Robert Parkes	Independent Lay Member, Lead for Governance from 1.9.2021	0-5	0	0-5	0-5	0-2.5	0-5
Wendy Bower	Independent Lay Member, Patient and Public Involvement from 1.7.2021	0-5	0	0-5	0-5	0-2.5	0-5

Notes:

- ** Taxable expenses and benefits in kind are expressed to the nearest £100.
- James Kent is Accountable Officer for the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) and is recharged from Buckinghamshire CCG. The remuneration for 2021/22 shown above is a proportion of his total salary and is based on “fair shares” (average registered population relative to the two other CCGs in the ICS) which equates to 40.15% for Oxfordshire.
- James Kent was contractually entitled to a performance bonus for 2021/22. Total Bonus due in 2021/22 was in the band £15-20k. The OCCG share of the bonus paid (40.15%) is shown above. 50% has been paid in 2021-22 with the remainder to be paid in 2022/23.
- Jo Cogswell and Sam Hart have lease cars from the CCG workplace lease car scheme. The taxable benefit is shown in the relevant column in the table.
- Kiren Collison acted as Clinical Chair for the CCG until 18.7.21. During the latter period of her employment with the CCG she was undertaking a secondment to NHS England for which the CCG was reimbursed. From 1.6.21 NHS England employed her directly, but they failed to inform the CCG of this revised arrangement and she was subsequently overpaid. The CCG are working with Dr Collison to recover the correct amount of overpaid salary and the disclosure in this report is the estimated salary to which she was entitled.
- The remuneration for Meenu Paul covers posts other than her senior officer role. Her remuneration for the non-management posts was in the range £35-40k.
- Robert Parkes and Wendy Bower are non-executive directors for Buckinghamshire CCG. As part of the transition to the new Integrated Care Board, their appointments were extended during the year to cover Oxfordshire CCG also. No recharges of cost have been made from Buckinghamshire CCG and there is therefore no cost to disclose in the remuneration table above.

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

Name	Title	Oxfordshire CCG Salary & Fees (Bands of £5000) £000	Taxable benefit (rounded to nearest £100) £00	Annual Performance Related Bonuses (Bands of £5000) £000	Long Term Performance Related Bonuses (Bands of £5000) £000	All Pension Related Benefits (Bands of £2500) £000	TOTAL Oxfordshire CCG (Bands of £5000) £000
Board members							
Ed Capo-Bianco	South East Locality Clinical Director	65-70	0	0-5	0-5	7.5-10	70-75
David Chapman	Oxford City Locality Clinical Director	65-70	0	0-5	0-5	0-2.5	65-70
Joanne Cogswell	Director of Transformation	115-120	1	0-5	0-5	27.5-30	140-145
Kiren Collison	Clinical Chair	25-30	0	0-5	0-5	10-12.5	35-40
Heidi Devenish	Practice Manager Representative	0-5	0	0-5	0-5	20-22.5	20-25
Sam Hart	Network Clinical Director North	45-50	3	0-5	0-5	0-2.5	45-50
Shelley Hayles	North Locality Clinical Director	70-75	0	0-5	0-5	0-2.5	70-75
Diane Hedges	Chief Operating Officer and Deputy Chief Executive	120-125	0	0-5	0-5	30-32.5	150-155
James Kent	Accountable Officer	65-70	0	5-10	0-5	35-37.5	100-105
Gareth Kenworthy	Director of Finance	120-125	1	0-5	0-5	27.5-30	150-155
Amar Latif	Interim Governing Body Member	35-40	0	0-5	0-5	7.5-10	45-50
Catherine Mountford	Director of Governance	110-115	0	0-5	0-5	17.5-20.0	130-135
Guy Rooney	Medical Specialist Advisor	10-15	0	0-5	0-5	0-2.5	10-15
Andy Valentine	City Network Clinical Director	75-80	0	0-5	0-5	5-7.5	80-85
Ursula Wiltshire	Board Nurse	80-85	0	0-5	0-5	0-2.5	80-85
Fiona Wise	Acting Accountable Officer and ICS Lead	20-25	0	0-5	0-5	0-2.5	20-25
Non Executive Board							
Roger Dickinson	Independent Lay Member, Lead for Governance and Vice Chair	20-25	0	0-5	0-5	0-2.5	20-25
Duncan Smith	Independent Lay Member, Lead for Finance	15-20	0	0-5	0-5	0-2.5	15-20
Louise Wallace	Independent Lay Member, Lead for Patient Participation and Involvement	10-15	0	0-5	0-5	0-2.5	10-15

Notes:

- James Kent is Accountable Officer for the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) and is recharged from Buckinghamshire CCG. The remuneration for 2020/21 shown above is a proportion of his total salary and is based on “fair shares” (average registered population relative to the two other CCGs in the ICS) which equates to 40.15% for Oxfordshire. James Kent was contractually entitled to a performance bonus for 2020/21. Total Bonus due in 2020-21 was in the band £15-20k. The OCCG share of the bonus paid in 2021-22 (40.15%) shown above was not previously reported in 2020-21 financial statements. The financial statements have now been restated to include this as a prior period adjustment.
- Fiona Wise was Acting Accountable Officer and ICS Lead for three months for Oxfordshire and Buckinghamshire CCG and was then replaced by James Kent. She was seconded from Buckinghamshire CCG so that the remuneration for 2020/21 shown above is a proportion of her total salary.
- The costs for Gareth Kenworthy were recharged in part to the ICS in 2019-20. In 2020-21 his costs are wholly within Oxfordshire CCG.
- Ursula Wiltshire was an Executive Director until 31 January 2021 and from 1 February has been an independent member of the Governing Body covering the role of Board Nurse.
- Louise Wallace left the CCG on 31.12.2020.
- Joanne Cogswell and Sam Hart have lease cars from the CCG workplace lease car scheme. The taxable benefit is shown in the relevant column in the table. Their salaries and fees have been restated as prior year adjustments.

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

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

1) Extended on 01/05/2018 to 30/04/2022 and then to 30/06/2022
2) Extended on 01/10/2020 to 31/03/2022
3) Extended on 01/04/2020 to 31/03/2023

Pension Benefits as at 31 March 2022

Name	Title	Notes	Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at pension age at 31 March 2022 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1st April 2021 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2022 £'000	Employer's contribution to stakeholder pension £'000
Board members										
Ed Capo-Bianco	Urgent & Emergency Care Portfolio Clinical Director		0-2.5	0-2.5	10-15	15-20	140	5	155	0
Kiren Collison	Clinical Chair to 18.7.2021		0-2.5	0-2.5	15-20	25-30	248	0	269	0
Joanne Cogswell	Director of Transformation		0-2.5	0-2.5	10-15	0-5	111	12	139	0
Heidi Devenish	Practice Manager Representative		0-2.5	0-2.5	5-10	0-5	52	13	65	0
Diane Hedges	Chief Operating Officer and Deputy Chief Executive		0-2.5	0-2.5	40-45	65-70	747	37	805	0
Gareth Kenworthy	Director of Finance		2.5-5	0-2.5	40-45	75-80	664	30	715	0
James Kent	Accountable Officer		2.5-5	0-2.5	5-10	0-5	67	27	125	0
Catherine Mountford	Director of Governance		0-2.5	0-2.5	45-50	125-130	1,042	46	1,108	0
Sam Hart	North Network Clinical Director		0-2.5	0-2.5	10-15	0-5	149	0	138	0
Andy Valentine	Oxford City Network Clinical Director		0-2.5	0-2.5	15-20	20-25	188	14	209	0
Meenu Paul	Clinical Lead		0-2.5	0-2.5	10-15	20-25	137	0	140	0

Notes:

- Kiren Collison acted as Clinical Chair for the CCG until 18.7.21. During the latter period of her employment with the CCG she was undertaking a secondment to NHS England for which the CCG was reimbursed. From 1.6.21 NHS England employed her directly but they failed to inform the CCG of this revised arrangement and she was subsequently overpaid. The CCG are working with Dr Collison to recover the correct amount of overpaid salary and the disclosure in this report is the estimated salary to which she was entitled.
- David Chapman chose not to be covered by the pension arrangements during the reporting year. Shelley Hayles and Ursula Wiltshire are retired senior officers.
- Lay members and the Medical Specialist advisor do not receive pensionable remuneration.
- "The calculations above do not take account of the McCloud judgement (This was a legal case which concluded there had been age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the eldest members who retained a Final Salary design). The outcome of the case means that all eligible members are members of their legacy scheme for the period between 1 April 2015 and 31 March 2022, known as the remedy period. Eligible members retiring after implementation will get a choice of whether to take legacy or reformed scheme benefits for the remedy period when their pension benefits become payable. This is known as the deferred choice underpin. NHS Pension Scheme regulations to allow for the implementation are being drafted following the enabling legislation known as the Public Service Pensions and Judicial Offices Act 2022 (which came into force in March 2022)."

Pension Benefits as at March 31 2021

Name	Title	Notes	Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at pension age at 31 March 2021 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1st April 2020 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2021 £'000	Employer's contribution to stakeholder pension £'000
Board members										
Ed Capo-Bianco	South East Locality Clinical Director		0-2.5	0-2.5	10-15	15-20	126	2	140	0
Joanne Cogswell	Director of Transformation		0-2.5	0-2.5	5-10	0	82	11	111	0
Kiren Collison	Clinical Chair		0-2.5	0-2.5	15-20	25-30	229	5	248	0
Heidi Devenish	Practice Manager Representative		0-2.5	0-2.5	0-5	0	39	12	52	0
Sam Hart	Network Clinical Director North		0-2.5	0-2.5	10-15	0	167	0	149	0
Diane Hedges	Chief Operating Officer and Deputy Chief Executive		0-2.5	0-2.5	35-40	65-70	684	33	747	0
James Kent	Accountable Officer		2.5-5	0-2.5	0-5	0-5	25	13	67	0
Gareth Kenworthy	Director of Finance		0-2.5	0-2.5	35-40	75-80	613	23	664	0
Amar Latif	Interim Governing Body Member		0-2.5	0-2.5	10-15	15-20	144	0	155	0
Catherine Mountford	Director of Governance		0-2.5	2.5-5	40-45	125-130	943	68	1,042	0
Andy Valentine	City Network Clinical Director		0-2.5	0-2.5	10-15	20-25	174	0	188	0

Notes:

- James Kent joined in May 2020 as Accountable Officer and ICS Lead.
- Lay members and Medical Specialist advisor do not receive pensionable remuneration.
- David Chapman, Shelley Hayles and Ursula Wiltshire chose not to be covered by the pension arrangements during the reporting year.
- "The calculations above do not take account of the McCloud judgement (This was a legal case which concluded there had been age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the eldest members who retained a Final Salary design). The outcome of the case means that all eligible members are members of their legacy scheme for the period between 1 April 2015 and 31 March 2022, known as the remedy period. Eligible members retiring after implementation will get a choice of whether to take legacy or reformed scheme benefits for the remedy period when their pension benefits become payable. This is known as the deferred choice underpin. The financial implications of this have not yet been worked through nationally or at an organisational level."

Cash Equivalent Transfer Value

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Real Increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Fair Pay Disclosure

The financial year 2021/22 figures from the Workforce Remuneration section has been updated in accordance with NHS GAM. 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.

Percentage change in renumeration of highest paid director

Percentage changes	21/22	20/21	Change	% Change
Highest paid director				
Salary and Allowances	152,500.00	152,500.00	-	0.00%
Performances and bonuses	0.00	0.00	-	0.00%
Employees of the entity taken as a whole (Average)				
Salary and Allowances	67,337.72	66,879.98	457.74	0.68%
Performances and bonuses	18,200.00	18,200.00	-	0.00%

There has been no change in the salary of the highest paid director year on year but overall employees' salaries have increased by 2.31% on average (pay award for 2021/22 was 3.0%).

Bonuses paid have been included in the calculation. Only one employee received a bonus in 2020/21 and 2021/22 and no other bonuses were received by the remaining workforce.

Pay Ratio Information

As at 31 March 2022, remuneration ranged from £23k to £155k (2020/21: £22k-£155k) based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Renumeration of NHS Oxfordshire CCG staff is shown in the table below:

2021-22	25th Percentile	Median	75th Percentile
Total remuneration (£)	40,573	53,219	80,432
Salary component of total remuneration (£)	40,573	53,219	80,432
Pay ratio information	3.76	2.87	1.90
2020-21	25th Percentile	Median	75th Percentile
Total remuneration (£)	38,890	51,668	84,000
Salary component of total remuneration (£)	38,890	51,668	84,000
Pay ratio information	3.92	2.95	1.82
Comparative	25th Percentile	Median	75th Percentile
Total remuneration (£)	1,683	1,551	-3,568
Salary component of total remuneration (£)	1,683	1,551	-3,568
Pay ratio information	-0.16	-0.09	0.08

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce

The banded remuneration of the highest paid director/member in NHS Oxfordshire CCG in the financial year 2021/22 was £150k -155k (2020/21: £150k - £155k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

In 2021/22, no (2020/21, 1) employee received remuneration in excess of the highest-paid director/member.

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.

The highest paid director's salary is 2.87 times the median salary compared to 2.95 last year. The 25th percentile ratio has also reduced slightly ie there is a slightly smaller gap between the salary of the highest paid director and the 25th percentile. There is a slight increase to the gap between the salary of the highest paid director and the 75th percentile. This may reflect structures of the national pay bands, changes to the skill mix of the CCG and changes to the pattern of use of agency staff.

The total annualized remuneration of James Kent was used in the calculation of average salary and pay ratios, but the highest paid director was determined using only the cost specific to OCCG.

Staff Report

Staff sickness absence

Below outlines OCCG's sickness absence data from 1 April 2021 to 31 March 2022.

	2021/22
Sum of full time equivalent (FTE)	197
Sum of FTE days available	29,844
Average annual sick days per FTE	1.5

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. Implementation is supported by an active staff led Health and Wellbeing Group who organise events throughout the year with a large number of staff participating. Whilst the COVID-19 pandemic affected mechanisms for these BOB CCGs supported externally facilitated 'Lets Talk and Support' session open to all staff, ran an internal staff survey identifying areas for improvement and have taken part in the national staff survey. There was 80% of staff completed the 2021 NHS national staff survey across the BOB CCGs with an average score across the three CCGs of 6.2 out of 10 saying they looked forward to coming to work and scoring of 7 out of 10 saying they were enthusiastic about their job. 2021 was the first year the BOB CCGs undertook the national staff survey so there is no trend data available.

Staff numbers and gender analysis

OCCG has a workforce comprised of employees from a wide variety of professional groups. At the end of 2021/22 OCCG employed 134 staff (headcount), of which 99 were women and 35 men. As of 31 March 2022, the Board of OCCG was made up of 5 women and 3 men. Below is a breakdown of gender analysis. The membership body of OCCG is made up of all 67 (as of 31 March 2022) GP practices within Oxfordshire; a breakdown of membership by gender is not available.

Below outlines the gender breakdown of staff:

	Female Headcount	Male Headcount	Total Headcount
CEO and Board	5	3	8
Very Senior Managers including GPs	6	11	17
All other Employees	88	21	109
Total Employees	99	35	134

The below table shows the number of people (headcount) employed by OCCG and other numbers, either employed by other organisations or temporary staff who are working for OCCG as at 31 March 2022

	Permanently employed Number	Other Numbers	20/21 Total Number
Total (headcount)	110	24	134

The below table shows the average number of people employed (whole time equivalent) by OCCG and other numbers either employed by other organisations or temporary staff working for OCCG during 2021/22.

	2021/2022 Permanently employed Number	Other Numbers	20/21 Total Number
Average number of whole time equivalent people	77.28	23.72	101.00
Of which: (WTE) people engaged on capital projects	0	0	0

Staff turnover for OCCG is 18.18%

Trade union official facility time

OCCG has one trade union representative who worked 9 hours (1.5 hours bi-monthly) during 2021/22 at a cost of £176.69.

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

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

Percentage of pay bill spent on facility time	
Provide the total cost of facility time	£177.00
Provide the total pay bill	£23,521.00
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.75%
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 £1,670k in 2021/22 (£29k in 2020/21) as per Note 5 in the financial accounts on page 106. OCCG acts as the host for ICS development funding. With the publication of the Health and Care Bill in 2021 and an expected establishment date of 1 April 2022 (deferred to 1 July 2022) for the new arrangements it has been necessary to commission external support to undertake the work required to prepare for the change and enable a safe transfer of functions from the CCGs to the ICB. A summary of the purpose of the larger contracts is:

- Berkeley Partnership LLP – developing the System Delivery Plan and ICS development work with system leaders to agree 2021/22 and 2022/23 system priorities preparatory work for development of the ICS strategy
- Camburg Collective Ltd – additional HR capacity to support due diligence and transfer
- GGI Development and Research LLP – reviewing governance arrangements of CCGs in transition to ensure single AO had oversight; development of ICB/ICS governance arrangements
- McKinsey and Company – analytics to support elective recovery and discharge flow and strategy development

Off Payroll Engagements

Under Treasury guidance PES (2013) 09, all public sector organisations are required to disclose information about high paid off payroll appointments. As at 31 March 2022 there were no off payroll engagements for more than £245 per day that lasted longer than six months. The CCG did not make any new off payroll engagements, or any that reached six months in duration, which cost more than £245 per day, between 1 April 2020 and 31 March 2021.

For any off-payroll engagements of Board members and senior officials with significant financial responsibility, between 01 April 2021 and 31 March 2022 – see below:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	0
Total no. of individuals on payroll and off-payroll who have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements. (2)	5

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

Exit Packages 2021/22

There were no exit packages in the year 2021/22 and consequently no associated payments.

Analysis of Other Agreed Departures

There were no departures made in the year 2021/22 or the previous year 2020/21 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 2021/22.

Health & wellbeing of staff

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

- The OCCG Health and Wellbeing Team channel was set up in MS Teams for staff to share lockdown-friendly entertainment and cooking recipe suggestions, as well as tips and ideas for maintaining fitness routines. This has continued through 2021/22
- Weekly Wellbeing Wednesday sessions began in June 2020 and are open to all OCCG staff and those across the BOB ICS; these sessions provide mindfulness activities and stretching exercises for staff to follow and have continued throughout the past year
- In addition, there have been seasonal quizzes and activities such as a pumpkin carving competition where staff were invited to submit photos of their Halloween creations.

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

The Employee Assistant Programme (EAP) is a free service for staff anonymously to access impartial advice and counselling services. The service supports staff with a range of things including managing stress, coping with bereavement, relationship breakdown, debt advice or a challenge or issue which could benefit from being talked through.
A weekly staff update commenced at the beginning of the pandemic; this went to fortnightly during 2021/22; it included lots of work-related information and also signposts to resources for mental and physical wellbeing. The update has been well received by staff across the organisation. In January this staff update moved to monthly for all staff across Buckinghamshire, Oxfordshire and Berkshire West CCGs.

Staff Policies

OCCG recognise and value the importance of maintaining positive working relationships with its staff and their representatives. Since December 2020 we have a Staff Partnership Forum (SPF) for all three CCGs to meeting together to form a single BOB wide forum. The SPF is a joint management and staff forum for staff engagement and consultation; a key focus of the BOB SPF is wellbeing and inclusion of staff.

Staff and managers from OCCG have actively and successfully worked with colleagues across BOB to align policies with those of Buckinghamshire and Berkshire West CCGs to support the development of the BOB ICB. Policies are ratified in line with the scheme of delegation prior to publication.

The BOB CCGs 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.

The CCG has a Health and Wellbeing Policy and an active, staff led, Health and Wellbeing Group which supports implementation of this policy which has been vital during the past year of the pandemic and different ways of working . Events are held throughout the year with a large number of staff participating. Events have included quizzes and events aimed to support employee's wellbeing. The Wellbeing Wednesday sessions commenced in 2020 are available to staff across the three CCGs.

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

- Weekly BOB CCGs Accountable Officer Staff Briefings
- CCG and BOB ICS Staff surveys to drive improvement in staff experience
- Staff development / training sessions with opportunities across the BOB CCGs

The results of the staff surveys have been assessed by the BOB SPF, themes identified and an action plans developed by staff to address different aspects of the feedback.

Disability information

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

case-by-case basis.

OCCG is committed to implementing the Workforce Race Equality Standards (WRES) and will work with those organisations it commissions services from and partners to ensure employees from black and ethnic minority backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The 2021 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.

Health and safety

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

Whistleblowing

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

Auditable elements

Please note that the elements of this remuneration and staff report that have been subject to audit are the tables of salaries and allowances of senior managers and related narrative notes on page 61 and 62, pension benefits of senior managers and related narrative on pages 64 and 65, the fair pay disclosures and related narrative notes on page 66 to 69 and exit packages and any other agreed departures on page 74 and 75.

Dr James Kent
Accountable Officer,
21 June 2022

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 2021/22 there were no remote contingent liabilities, gifts, fees or charges. Below outlines the total number of OCCG's losses and special payments cases, and their total value:

	Total number of cases	**Total value of cases**	Total number of cases	Total value of cases
	2021/22	**2021/22**	2020/21	2020/21
	Number	**£'000**	Number	£'000
Fruitless payments	0	0	2	1
Cash losses	1	0*	1	0*
Total	1	0*	3	1

* Value of loss < £500 so rounded down

Dr James Kent
Accountable Officer
21 June 2022

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

Opinion

We have audited the financial statements of NHS Oxfordshire Clinical Commissioning Group ("the CCG") for the year ended 31 March 2022 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 20, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by the 2021/22 HM Treasury's Financial Reporting Manual (the 2021/22 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2021/22 and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England).

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Oxfordshire Clinical Commissioning Group as at 31 March 2022 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021 to 2022; and
- have been properly prepared in accordance with the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of Matter – Transition to an Integrated Care Board

We draw attention to Note 19 - Events After the End of the Reporting Period, which describes the Clinical Commissioning Group's transition into the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board from the 1 July 2022. Our opinion is not modified in respect of this matter.

Conclusions relating to going concern

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

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's, or the successor body's, ability to continue as a going concern for a period of at least 12 months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the CCG's ability to continue as a going concern.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report.

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

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

We have nothing to report in this regard.

Opinion on the Remuneration and Staff Report

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued in the Department of Health and Social Care Group Accounting Manual 2021/22; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 (as amended) because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we make a written recommendation to the CCG under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We have nothing to report in these respects.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's Responsibilities in respect of the Accounts, set out on pages 45-46, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial

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

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

Auditor's responsibility for the audit of the financial statements

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

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

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

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

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

We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur by planning and executing a journal testing strategy, testing the appropriateness of relevant entries and adjustments. We have considered whether judgements made are indicative of potential bias and considered whether the CCG is engaging in any transactions outside the usual course of business. In response to the risk of fraud in revenue and expenditure recognition for year-end accruals, we reviewed and tested revenue and expenditure accounting policies, year-end accruals, and expenditure cut-off at the period end date. We specifically focused on key aspects of unrecorded liabilities to provide assurance that the year-end accounts were free from material misstatement; we reviewed Covid19 income and expenditure and how it had been accounted for, and performed substantive procedures on Department of Health agreement of balances data, investigating significant differences outside of Department of Health tolerances.

Based on this understanding we designed our audit procedures to identify noncompliance with such laws and regulations. Our procedures involved enquiry of management and those charged with

governance, reading and reviewing relevant meeting minutes of those charged with governance and the Governing Body and understanding the internal controls in place to mitigate risks related to fraud and non-compliance with laws and regulations. Oxfordshire CCG has robust policies and procedures to mitigate potential for override of controls, there is a culture of ethical behaviour, supported by a number of policies in respect of human resources and counter fraud, bribery and corruption.

We addressed our fraud risk related to management override through implementation of a journal entry testing strategy, assessing accounting estimates for evidence of management bias and evaluating the business rationale for significant unusual transactions.

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

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

We have undertaken our review in accordance with the Code of Audit Practice 2020, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in December 2021 as to whether the CCG had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

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

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

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

Report on Other Legal and Regulatory Requirements

Regularity opinion

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

We are required to obtain evidence sufficient to give an opinion on whether in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

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

Certificate

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have issued our Auditor's Annual Report for the year ended 31 March 2022. We have completed our work on the value for money arrangements and will report the outcome of our work in our commentary on those arrangements within the Auditor's Annual Report.

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

Use of our report

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

Janet Dawson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
London
21 June 2022

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: general practitioner (GP) at the head of Oxfordshire Clinical Commissioning Group.

Elective care: care that is planned in advance is known as elective care. It involves specialist clinical care or surgery, generally following a referral from a GP or community health professional.

Emergency care: services for life threatening illnesses or accidents which require immediate, intensive treatment. Services that should be accessed in an emergency include ambulance (via 999) and emergency departments.

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

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 NHS Trust, Oxfordshire Mind, Restore, Response, Connection Floating Support and Elmore Community Services

National Institute for Clinical Excellence (NICE): 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 NHS Foundation Trust (Oxford Health): 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 (OUH): 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.

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.

Single Point of Access: this provides one number and one email address for referrals to secondary mental health services and support in a mental health crisis.

Urgent care: services for an illness or injury that requires urgent attention but is not a life-threatening situation. Urgent care services include a phone consultation through the NHS 111 Clinical Assessment Service, pharmacy advice, out-of-hours GP appointments, and/or referral to an urgent treatment centre.

Appendix 1: Table of Attendance for Board and Committee Meetings

Key:

Present	**Y**
Apologies/Absent	**A**
N/A	

Oxfordshire Clinical Commissioning Group - Governing Body Meetings 2021/22

Oxfordshire CCG Attendees	**14/4/21**	**11/5/21**	**10/6/21**	**13/7/21**	**August**	**9/9/21**	**12/10/21**	**11/11/21**	**December**	**13/1/22**	**8/2/22**	**10/3/22**
Dr James Kent	Y	Y	Y	Y	No Meetings took place in August	Y	Y	Y	No meeting took place in December	Y	Y	Y
Voting Members												
*Wendy Bower						Y	Y	Y		Y	Y	Y
Ed Capo-Bianco	Y	Y	A	A		A	Y	Y		Y	Y	Y
Dr David Chapman	Y	Y	Y	Y		Y	Y	Y		Y	Y	Y
Dr Kiren Collison		Y	Y	Y								
Roger Dickinson	Y	Y	Y									
Dr Sam Hart	A	Y	Y	Y		Y	A	Y		Y	Y	Y
Dr Shelley Hayles	A	A	A	Y		Y	A	Y		A	Y	Y
Gareth Kenworthy	Y	Y	Y	Y		A	Y	Y		Y	Y	Y
*Robert Parkes						A	Y	Y		Y	Y	Y
Dr Meenu Paul						A	Y	A		Y	Y	A
Dr Guy Rooney	Y	Y	Y	Y		Y	Y	Y		Y	A	A
Duncan Smith	Y	Y	Y	Y		Y	Y	Y		Y	A	Y
Dr Andy Valentine	Y	A	Y	Y		Y	Y	Y		Y	Y	Y
Sula Wiltshire	Y	A	Y	Y		Y	Y	Y		Y	A	Y

Non-Voting members										
Ansaf Azhar (deputy)	Y	Y	Y	A	Y	Y	A	Y	Y	A
Stephen Chandler	Y	Y	A	A	Y	Y	Y	Y	Y	A
Jo Cogswell	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Heidi Devenish	Y	A	Y	Y	Y	Y	Y	Y	Y	A
Diane Hedges	Y	Y	A	Y	Y	A	Y	Y	Y	Y
Catherine Mountford	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Oxfordshire Clinical Commissioning Group - Quality Committee Meetings 2021/22

Attendees	May 21	October 21	January 22
Voting Members			
Dr Guy Rooney	Y	Y	Y
Helen Ward	Y	Y	Y
Debbie Simmons	Y	Y	Y
Diane Hedges	A	A	Y
Shakiba Habibula	Y	Y	Y
Pippa Corner	Y	Y	A
Marie Crofts	Y	Y	Y
Rob Bale	Y	Y	Y
Karl Marlowe	A	Y	Y
Dr Kathryn Brown	Y	Y	Y
Professor Helen Young	Y	Y	Y
Dr Andy Valentine	Y	Y	A
Dr Meenu Paul	Y	Y	Y
Sam Foster	Y	Y	A
Non-Voting Members			
Katherine Edwards	A	Y	Y

Hillary Seal	Y	A	Y
Rosalind Pearce	Y	Y	Y

Oxfordshire Clinical Commissioning Group – Remuneration Committee Meetings 2021/22

Attendees	02/06/2021	21/09/2021	18/01/2022	09/08/2021	13/08/2021	15/12/2021	16/02/2022	22/03/2022
Wendy Bower	Y	Y	Y					Y
David Chapman		A	A	Virtual meetings were held on these dates. Attendance was not recorded.				A
Kiren Collison	A							
Roger Dickinson	Y							
Robert Parkes	Y	Y	Y					Y
Duncan Smith	Y	Y	Y					Y

Oxfordshire Clinical Commissioning Group – Audit Committee Meetings 2021/22

Attendees	28/07/2021	27/10/2021	26/01/2022
Wendy Bower	Y	Y	A
Gareth Kenworth	A	Y	Y
Catherine Mountford	Y	Y	Y
Robert Parkes	Y	Y	Y
Duncan Smith	Y	Y	Y
Jenny Simpson	Y	Y	A

Oxfordshire Clinical Commissioning Group – Finance Committee Meetings 2021/22

Attendees	29/4/21	01/06/21	24/06/21	02/09/21	07/10/21	04/11/21	02/12/21	03/02/22	03/03/22
James Kent	Y	Y	A	A	A	Y	A	A	A
Roger Dickinson	Y	Y	Y						
Gareth Kenworthy	Y	Y	Y	Y	Y	Y	Y	Y	Y
Duncan Smith	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ed Capo-Bianco	Y	Y	Y	Y	Y	Y	Y	Y	Y
Diane Hedges	Y	Y	Y	Y	Y	Y	Y	Y	Y
Julia Boyce	Y								
Jenny Simpson	Y	Y	Y	Y	Y	Y	Y	A	Y
Robert Parkes	Y	Y	Y	A	Y	Y	Y	Y	A

Oxfordshire Clinical Commissioning Group – Primary Care Commissioning Committee Meetings 2021/22

Attendees	13/07/2021	16/09/2021	16/12/2021	17/03/2022
Dr James Kent	A	A	Meeting cancelled	A
Duncan Smith	Y	Y		Y
David Chapman		Y		Y
Jo Cogswell	Y	Y		Y
Dr Meenu Paul	Y	Y		Y

Oxfordshire Clinical Commissioning Group Executive Committee Meetings 2021/22

Attendees	27/04/21	25/05/21	22/06/21	27/07/21	24/08/21	28/09/21	26/10/21	23/11/21	25/01/22	22/02/22	3/03/22
Ed Capo-Bianco	Y	Y	Y	Y	A	Y	Y	Y	Y	Y	Meeting cancelled
David Chapman	Y	A	A	Y	Y	A	Y	Y	Y	Y	
Jo Cogswell	Y	Y	Y	Y	Y	Y	A	Y	Y	A	
Kiren Collison	Y	Y	Y								
Sam Hart	Y	Y	Y	Y	Y	Y	A	Y	Y	Y	
Shelley Hayles	Y	A	Y	Y	Y	A	Y	Y	Y	Y	
Diane Hedges	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Gareth Kenworthy	Y	Y	A	A	Y	Y	Y	Y	Y	Y	
James Kent	A	A	A	A	A	Y	Y	Y	Y	Y	
Catherine Mountford	Y	Y	A	Y	Y	Y	Y	Y	Y	Y	
Andy Valentine	Y	Y	Y	A	Y	A	A	Y	Y	Y	

Entity name:	NHS Oxfordshire Clinical Commissioning Group
This year	2021-22
Last year	2020-21
This year ended	31-March-2022
Last year ended	31-March-2021
This year commencing:	01-April-2021
Last year commencing:	01-April-2020

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The Primary Statements:

Statement of Comprehensive Net Expenditure for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Income from sale of goods and services	2	(3,393)	(1,160)
Other operating income	2	(596)	(305)
Total operating income		**(3,989)**	**(1,465)**
Staff costs	4	7,748	6,839
Purchase of goods and services	5	1,274,896	1,081,327
Depreciation and impairment charges	5	131	232
Provision expense	5	(23)	(624)
Other Operating Expenditure	5	564	514
Total operating expenditure		**1,283,316**	**1,088,289**
Net Operating Expenditure		**1,279,327**	**1,086,823**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**1,279,327**	**1,086,823**
Comprehensive Expenditure for the year		**1,279,327**	**1,086,823**

The notes on pages 97 to 124 form part of this statement

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Non-current assets:			
Property, plant and equipment	8	58	181
Intangible assets	9	32	40
Total non-current assets		90	221
Current assets:			
Trade and other receivables	10	14,793	6,553
Cash and cash equivalents	11	177	0
Total current assets		**14,971**	6,553
Total assets		**15,061**	6,774
Current liabilities			
Trade and other payables	12	(80,863)	(68,776)
Borrowings	13	-	(1,049)
Provisions	14	(1,232)	(1,331)
Total current liabilities		**(82,095)**	(71,157)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(67,034)**	(64,382)
Non-current liabilities			
Total non-current liabilities		**-**	-
Assets less Liabilities		**(67,034)**	(64,382)
Financed by Taxpayers' Equity			
General fund		(67,034)	(64,382)
Total taxpayers' equity:		**(67,034)**	(64,382)

The notes on pages 97 to 124 form part of this statement

The financial statements on pages 93 to 96 were approved by the Governing Body on 15 June 2022 and signed on its behalf by:

Accountable Officer
ent

Director of Finance
Gareth Kenworthy

Statement of Changes In Taxpayers Equity for the year ended 31 March 2022

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22				
Balance at 01 April 2021	(64,382)	0	0	**(64,382)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22				
Net operating expenditure for the financial year	(1,279,327)			**(1,279,327)**
Net funding	1,276,676	0	0	**1,276,676**
Balance at 31 March 2022	**(67,034)**	**0**	**0**	**(67,034)**

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

The notes on pages 97 to 124 form part of this statement

Statement of Cash Flows for the year ended
31 March 2022

	Note	**2021-22** **£'000**	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(1,279,327)	(1,086,823)
Depreciation and amortisation	5	131	232
(Increase)/decrease in trade & other receivables	10	(8,240)	4,179
Increase/(decrease) in trade & other payables	12	12,099	2,953
Provisions utilised	14	(76)	(187)
Increase/(decrease) in provisions	14	(23)	(624)
Net Cash Inflow (Outflow) from Operating Activities		**(1,275,437)**	(1,080,271)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		(13)	(39)
(Payments) for intangible assets		0	(40)
Net Cash Inflow (Outflow) from Investing Activities		**(13)**	(79)
Net Cash Inflow (Outflow) before Financing		**(1,275,449)**	(1,080,349)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		1,276,676	1,080,527
Net Cash Inflow (Outflow) from Financing Activities		**1,276,676**	1,080,527
Net Increase (Decrease) in Cash & Cash Equivalents	11	**1,226**	178
Cash & Cash Equivalents at the Beginning of the Financial Year		**(1,049)**	(1,227)
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**177**	(1,049)

The notes on pages 97 to 124 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2021-22 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

As set out in Note 19 – Events after the Reporting Period, on 28 April 2022, the Health and Care Act 2022 received Royal Assent. As a result, Clinical Commissioning Groups will be abolished and the functions, assets and liabilities of Oxfordshire CCG will transfer to Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board from the 1 July 2022.

Where a CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. It remains the case that the Government has issued a mandate to NHS England and NHS Improvement for the continued provision of services in England in 2022/23 and CCG published allocations can be found on the NHS England website for 2022/23 and 2023/24. The commissioning of health services (continuation of service) will continue after 1 July 2022 but will be through the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board, rather than Oxfordshire CCG.

Mergers or a change to the NHS Structure, such as the transfer of CCG functions to the ICB, is not considered to impact on going concern. Our considerations cover the period through to 30 June 2023, being 12 months beyond the date of authorisation of these financial statements. Taking into account the information summarised above, the Governing Body have a reasonable expectation that the CCG (and the successor commissioning organisation) will have adequate resources to continue in operational existence for the foreseeable future.

1.2 Accounting Convention

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

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

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

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

1.4 Joint arrangements

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

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

The Clinical Commissioning Group has entered into a pooled budget arrangement with Oxfordshire County Council in accordance with section 75 of the National Health Service Act 2006. Under the arrangement, funds are pooled within a Better Care Fund (BCF) pool to provide services to adults with disabilities and older adults requiring health and social care. The Adults with Care and Support Needs (ACSN) pool is to provide health and social care services for adults with learning disabilities, and children and adults with mental health problems. Note 17 provides details of the income and expendture of the pools.

The pools are hosted by Oxfordshire County Council, although the Mental Health element of the ACSN pool is hosted by Oxfordshire Clinical Commissioning Group. The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

In 2020-21, the County Council and the CCG developed a new HESC (Health Education and Social Care) model for joint commissioning. The new governance structure went live from 1st April 2021 in the form of a new Joint Commissioning Executive (JCE). It was expected that a new Section 75 agreement would be enacted during 2021-22 but, whilst work has progressed in this area, it has been decided to extend the current agreement into 2022-23 until such time as the new ICB (Integrated Care Board) is assured around the financial implications.

1.5 Operating Segments

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

Notes to the financial statements

1.6 **Revenue**

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

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

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

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

Payment terms are standard reflecting cross government principles.

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

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

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

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

1.7.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

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

1.8 **Other Expenses**

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

1.9 **Grants Payable**

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

1.10 **Property, Plant & Equipment**

1.10.1 **Recognition**

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

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

Notes to the financial statements

1.1 Property, Plant & Equipment cont'd

1.10.2 **Measurement**

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

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

1.10.3 **Subsequent Expenditure**

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

1.11 **Intangible Assets**

1.11.1 **Recognition**

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

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

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

1.11.2 **Measurement**

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

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

1.11.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

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

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

Notes to the financial statements

1.12 **Leases**

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

1.12.1 **The Clinical Commissioning Group as Lessee**

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

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

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

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

1.13 **Cash & Cash Equivalents**

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

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

1.14 **Provisions**

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

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 0.95% (2020-21 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.15 **Clinical Negligence Costs**

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

1.16 **Non-clinical Risk Pooling**

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

Notes to the financial statements

1.17 **Contingent liabilities and contingent assets**

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

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

1.18 **Financial Assets**

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

Financial assets are classified into the following categories:
- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

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

1.18.1 **Impairment**

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

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

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

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

1.19 **Financial Liabilities**

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

1.20 **Value Added Tax**

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

1.21 **Losses & Special Payments**

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

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

Notes to the financial statements

1.22 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions about the carrying amounts of assets and liabilities. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are regularly reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

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

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

- The pooled budget arrangements, including the Better Care Fund, have been judged to be joint operations under IFRS 11, i.e. involve the contractually agreed sharing of control but not through a separate vehicle. The contractual arrangements (Section 75 agreements) establish the parties' rights to the assets, and obligations for the liabilities relating to the arrangement, and the parties' rights to the corresponding revenues and obligations to the corresponding expenses. Note 17 sets out the rights and obligations of the Clinical Commissioning Group in relation to the pooled arrangements.

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

1.22.2 **Sources of estimation uncertainty**

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

- The Clinical Commissioning Group generates provisions to cover future liabilities of more than one year. Such provisions are estimated by management based on knowledge of the business and assumptions of probability. They are reviewed on an annual basis. The CCG's main provision £1.2m at at 31 March 2022 is in respect of Continuing Healthcare. This provision represents the CCG's share of the estimated liability to pay claims in respect of continuing healthcare assessments. The provision is estimated from the assessment of clients on the waiting list, average costs of care, average number of weeks that care is needed and average interest rates. Actual claims settled may differ from those calculated.

- Accruals are calculated based on management knowledge, market intelligence ad contractural arrangements. The accruals cover areas such as prescribing, contracts for healthcare and non healthcare services. Estimates of partially completed spells and maternity pathway prepayment are not required this year due to the nature of the block contracting arrangements in place in 2021-22 as part of the response to the pandemic. Prescribing accruals reflect the last two months of the financial year for which actual information is not available. They are based on forecasts received from the Business Services Authority amended to reflect the medicines management team's best assessment of pressures that may impact on the final position.

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

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.
● IFRS 16 Leases – IFRS 16 Leases has been deferred until 1 April 2022, but CCGs will still need to provide adequate disclosure on the impact of the new standard. HM Treasury have issued application guidance which will assist entities in assessing the impact and this can be found at IFRS_16_Application_Guidance_December_2020.pdf (publishing.service.gov.uk).

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The clinical commissioning group will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the clinical commissioning group will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the clinical commissioning group's incremental borrowing rate. The clinical commissioning group's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the clinical commissioning group will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The impact of adopting IFRS 16 has been assessed and as at 31 March 2022, the CCG has no leases that fall within the scope of the standard. Leased assets will in future be disclosed on the SOFP subject to transitional arrangements set out in the FREM.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

2 Other Operating Revenue

	2021-22 Total	2020-21 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**2,742**	393
Prescription fees and charges	**590**	767
Other Contract income	**61**	-
Total Income from sale of goods and services	**3,393**	**1,160**
Other operating income		
Other non contract revenue	**596**	305
Total Other operating income	**596**	**305**
Total Operating Income	**3,989**	**1,465**

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

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

	Non-patient care services to other bodies	Prescription fees and charges
	£'000	£'000
Source of Revenue		
NHS	**1,211**	0
Non NHS	**1,531**	590
Total	**2,742**	**590**
Timing of Revenue		
Point in time	**2,742**	590
Total	**2,742**	**590**

4. Employee benefits and staff numbers

4.1.1 Employee benefits	**Total**		**2021-22**
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	**5,384**	**956**	**6,340**
Social security costs	**539**	**0**	**539**
Employer Contributions to NHS Pension scheme	**858**	**0**	**858**
Other pension costs	**0**	**0**	**0**
Apprenticeship Levy	**10**	**0**	**10**
Other post-employment benefits	**0**	**0**	**0**
Other employment benefits	**0**	**0**	**0**
Termination benefits	**0**	**0**	**0**
Gross employee benefits expenditure	6,792	956	7,748
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	6,792	956	7,748
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	6,792	956	7,748

4.1.1 Employee benefits	Total		2020-21
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**4,747**	**706**	5,453
Social security costs	**514**	**0**	514
Employer Contributions to NHS Pension scheme	**862**	**0**	862
Apprenticeship Levy	**9**	**0**	**9**
Gross employee benefits expenditure	6,133	706	6,839
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	6,133	706	6,839
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	6,133	706	6,839

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

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

4.2 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

4.2.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

4.2.2 Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

5. Operating expenses

	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	497	7,802
Services from foundation trusts	857,648	707,485
Services from other NHS trusts	3,721	5,967
Purchase of healthcare from non-NHS bodies	153,807	135,368
Prescribing costs	95,787	93,532
GPMS/APMS and PCTMS	123,918	113,641
Supplies and services – clinical	2,847	2,594
Supplies and services – general	32,193	6,732
Consultancy services	1,670	29
Establishment	2,315	1,178
Transport	1	0
Premises	2	6,525
Audit fees	138	85
Other professional fees	164	173
Legal fees	113	101
Education, training and conferences	76	116
Total Purchase of goods and services	**1,274,896**	**1,081,327**
Depreciation and impairment charges		
Depreciation	123	232
Amortisation	8	-
Total Depreciation and impairment charges	**131**	**232**
Provision expense		
Change in discount rate	-	-
Provisions	(23)	(624)
Total Provision expense	**(23)**	**(624)**
Other Operating Expenditure		
Chair and Non Executive Members	118	112
Grants to Other bodies	25	(20)
Research and development (excluding staff costs)	421	421
Other expenditure	-	1
Total Other Operating Expenditure	**564**	**514**
Total operating expenditure	**1,275,568**	**1,081,450**

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

Note 5 includes expenditure incurred by the clinical commissioning group acting as the host for the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS). Oxfordshire Clinical Commissioning group receives allocations on behalf of the ICS which are then spent across the three counties in accordance with the priorities of the ICS. Allocations from NHS England totalling £121.6m were received in 2021-22 (£16.5m in 2020-21) on behalf of the ICS, of which £82.5m was transferred across the 3 CCGs (£7.3m in 2020-21) leaving hosted ICS allocations of £38.2m within the CCG (£9.2m in 2020-21). Corresponding expenditure is mainly shown in Table 5 under Supplies and services – general and Services from other CCGs.

The base External Audit fee for 2021-22 is £70k excluding VAT (2020-21 £70k). An additional fee is expected for 2021-22 but has not yet been agreed. An estimate of the additional fees including VAT are reflected in the 2021-22 fees shown above.

6.1 Better Payment Practice Code

Measure of compliance	**2021-22 Number**	**2021-22 £'000**	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	8,573	241,032	4,152	151,079
Total Non-NHS Trade Invoices paid within target	8,188	235,836	3,924	148,222
Percentage of Non-NHS Trade invoices paid within target	**95.51%**	**97.84%**	**94.51%**	**98.11%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	907	909,363	2,125	750,127
Total NHS Trade Invoices Paid within target	874	908,201	2,054	747,401
Percentage of NHS Trade Invoices paid within target	**96.36%**	**99.87%**	**96.66%**	**99.64%**

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The target for achievement is greater than 95%.

7. Operating Leases

7.1 As lessee

7.1.1 Payments recognised as an Expense

	2021-22		2020-21	
	Buildings	**Total**	Buildings	Total
	£'000	**£'000**	£'000	£'000
Payments recognised as an expense				
Minimum lease payments	(16)	**(16)**	1,691	**1,691**
Total	**(16)**	**(16)**	**1,691**	**1,691**

7.1.2 Future minimum lease payments

	2021-22		2020-21	
	Buildings	**Total**	Buildings	Total
	£'000	**£'000**	£'000	£'000
Payable:				
No later than one year	239	**239**	343	**343**
Between one and five years	-	**-**	243	**243**
Total	**239**	**239**	**586**	**586**

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

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

8 Property, plant and equipment

2021-22	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2021	821	873	1,695
Additions purchased	0	-	0
Cost/Valuation at 31 March 2022	**821**	**873**	**1,695**
Depreciation 01 April 2021	697	816	1,514
Charged during the year	66	57	123
Depreciation at 31 March 2022	**763**	**873**	**1,637**
Net Book Value at 31 March 2022	**58**	**0**	**58**
Purchased	58	0	58
Total at 31 March 2022	**58**	**0**	**58**
Asset financing:			
Owned	58	0	58
Total at 31 March 2022	**58**	**0**	**58**

8.1 Economic lives

	Minimum Life (years)	Minimum Life (years)
Information technology	2	5
Furniture & fittings	5	10

9 Intangible non-current assets

2021-22	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2021	40	**40**
Additions purchased	-	**-**
Cost / Valuation At 31 March 2022	**40**	**40**
Amortisation 01 April 2021	-	**-**
Charged during the year	8	**8**
Amortisation At 31 March 2022	**8**	**8**
Net Book Value at 31 March 2022	**32**	**32**
Purchased	32	**32**
Total at 31 March 2022	**32**	**32**

9.1 Economic lives

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

10.1 Trade and other receivables	**Current 2021-22 £'000**	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS receivables: Revenue	8	-	52	-
NHS prepayments	-	-	-	-
NHS accrued income	660	-	51	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	-	-
NHS Non Contract trade receivable (i.e pass through funding)	980	-	199	-
Non-NHS and Other WGA receivables: Revenue	1,911	-	364	-
Non-NHS and Other WGA prepayments	1,523	-	784	-
Non-NHS and Other WGA accrued income	805	-	818	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	1,593	-	28	-
Expected credit loss allowance-receivables	(3)	-	(3)	-
VAT	245	-	51	-
Other receivables and accruals	7,070	-	4,209	-
Total Trade & other receivables	**14,793**	**-**	**6,553**	**-**
Total current and non current	**14,793**		**6,553**	
Included above:				
Prepaid pensions contributions	-		-	

10.2 Receivables past their due date but not impaired	**2021-22 DHSC Group Bodies £'000**	**2021-22 Non DHSC Group Bodies £'000**	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000
By up to three months	3	1,879	20	6
By three to six months	26	6	47	19
By more than six months	4	0	92	339
Total	**33**	**1,886**	**158**	**364**

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

11 Cash and cash equivalents

	2021-22	2020-21
	£'000	£'000
Balance at 01 April 2021	(1,049)	(1,227)
Net change in year	1,226	178
Balance at 31 March 2022	**177**	**(1,049)**
Made up of:		
Cash with the Government Banking Service	177	0
Cash with Commercial banks	-	-
Cash in hand	-	0
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**177**	**0**
Bank overdraft: Government Banking Service	-	(1,049)
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**(1,049)**
Balance at 31 March 2022	**177**	**(1,049)**

The overdraft in financial year 2020-21 relates to a timing difference of cash in transit. The Clinical Commissioning Group was contractually obliged to pay some suppliers of healthcare services on the 1st April 2021 so had to process a BACS payment run in March to achieve this. The overdraft is disclosed as borrowing in Note 13 and in the Statement of Financial position. There was no overdraft in 2021-22.

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

12 Trade and other payables	**Current 2021-22 £'000**	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS payables: Revenue	2,706	-	7,629	-
NHS accruals	3,572	-	3,799	-
Non-NHS and Other WGA payables: Revenue	15,261	-	6,533	-
Non-NHS and Other WGA payables: Capital	-	-	13	-
Non-NHS and Other WGA accruals	25,288	-	25,326	-
Non-NHS and Other WGA deferred income	80	-	111	-
Social security costs	75	-	74	-
VAT	-	-	-	-
Tax	56	-	62	-
Payments received on account	-	-	-	-
Other payables and accruals	33,824	-	25,229	-
Total Trade & Other Payables	**80,863**	**-**	**68,776**	**-**
Total current and non-current	**80,863**		**68,776**	

Other payables includes £16.0m outstanding payments to GP practices/other similar entities, £6.5m outstanding payments for Hosted BOB ICS entities, £8.5m representing the CCGs share of the pooled budget current liabilities and £1.0m outstanding pension contributions at 31 March 2022.

13 Borrowings	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
Bank overdrafts:				
· Government banking service	-	-	1,049	-
· Commercial banks	-	-	-	-
Total overdrafts	**-**	**-**	**1,049**	**-**
Total Borrowings	**-**	**-**	**1,049**	**-**
Total current and non-current	**-**		**1,049**	

13.1 Repayment of principal falling due

	Department of Health 2021-22 £'000	Other 2021-22 £'000	Total 2021-22 £'000
Within one year	-	-	-
Total	**-**	**-**	**-**

The overdraft in financial year 2020-21 relates to a timing difference of cash in transit. The Clinical Commissioning Group was contractually obliged to pay some suppliers of healthcare services on the 1st April 2021 so had to process a BACS payment run in March to achieve this. The overdraft is disclosed as borrowing in this note and in the Statement of Financial position. There is no overdraft in 2021-22.

14 Provisions

	Current 2021-22 £'000	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
Continuing care	1,232	-	1,331	-
Other	-	-	-	-
Total	**1,232**	**-**	**1,331**	**-**
Total current and non-current	**1,232**		**1,331**	

	Continuing Care £'000	**Other £'000**	**Total £'000**
Balance at 01 April 2021	1,331	-	1,331
Arising during the year	322	-	322
Utilised during the year	(76)	-	(76)
Reversed unused	(346)	-	(346)
Balance at 31 March 2022	**1,232**	-	**1,232**
Expected timing of cash flows:			
Within one year	1,232	-	1,232
Balance at 31 March 2022	**1,232**	-	**1,232**

Legal claims are calculated from the number of claims currently lodged with the NHS Litigation Authority and the probabilities provided by them. There were no legal claims outstanding at 31 March 2022 (31 March 2021 £0).

There is one provision of £30k included by the NHS Litigation Authority as at 31 March 2021 in respect of clinical negligence liabilities of the clinical commissioning group (31 March 2021 £0).

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

15 Financial instruments cont'd

15 Financial instruments

15.1 Financial risk management

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

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

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

15.1.1 Currency risk

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

15.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

15.1.3 Credit risk

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

15.1.4 Liquidity risk

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

15.1.5 Financial Instruments

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

15 Financial instruments cont'd

15.2 Financial assets

	Financial Assets measured at amortised cost 2021-22 £'000	Equity Instruments designated at FVOCI 2021-22 £'000	Total 2021-22 £'000
Trade and other receivables with NHSE bodies	641		641
Trade and other receivables with other DHSC group bodies	1,597		1,597
Trade and other receivables with external bodies	10,789		10,789
Cash and cash equivalents	177		177
Total at 31 March 2022	**13,204**	**-**	**13,204**

15.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2021-22 £'000	Other 2021-22 £'000	Total 2021-22 £'000
Trade and other payables with NHSE bodies	1,143		**1,143**
Trade and other payables with other DHSC group bodies	6,296		**6,296**
Trade and other payables with external bodies	73,212		**73,212**
Total at 31 March 2022	**80,651**	**-**	**80,651**

16 Operating segments

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

17 Joint arrangements - interests in joint operations

CCGs should disclose information in relation to joint arrangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

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

	2021-22 £'000	2020-21 £'000
Income	200,318	175,406
Expenditure	-200,318	-175,406

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

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

In 2020-21, the County Council and the CCG developed a new HESC (Health Education and Social Care) model for joint commissioning. The new governance structure went live from 1st April 2021 in the form of a new Joint Commissioning Executive (JCE). It was expected that a new Section 75 agreement would be enacted during 2021-22 but, whilst work has progressed in this area, it has been decided to extend the current agreement into 2022-23 until such time as the new ICB (Integrated Care Board) is assured around the financial implications.

17 Joint arrangements - interests in joint operations cont'd

BETTER CARE FUND POOLED BUDGET

The Better Care Fund pooled budget is hosted by Oxfordshire County Council (OCC). The Clinical Commissioning Group makes contributions to the pool, which are then used to purchase healthcare services. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement. In 2021-22 any over or underspends on this pool were not risk shared but were aligned ie they accrued to the partner to whom they related.

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

BETTER CARE FUND MEMORANDUM of ACCOUNT for the year ending 31 March 2022

	Total Contributions £'000
Partner Contributions	
Oxfordshire Clinical Commissioning Group	108,158
Oxfordshire CC Social & Community Services Directorate	107,257
Total Funding	215,415
Total Expenditure	215,415
Net (Under)/Overspend	0

Balance Sheet

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

	31 March 2022 £'000
CURRENT ASSETS	
Debtors - Amounts falling due within 1 year	
Other prepayments and accrued income	7,375
TOTAL CURRENT ASSETS	7,375
Creditors - Amounts falling due within 1 year	
Accruals and deferred income	-2,344
NET CURRENT ASSETS / (LIABILITIES)	5,031
Provisions for Liabilities & Charges	-5,031
TOTAL ASSETS EMPLOYED	0
FINANCED BY:	
TAXPAYERS' EQUITY	
Reserve	0
TOTAL TAXPAYERS' EQUITY	0

17 Joint arrangements - interests in joint operations cont'd

ADULTS WITH CARE AND SUPPORT NEEDS POOLED BUDGET

The Mental Health and Autism elements of the ACSN pool are hosted by Oxfordshire Clinical Commissioning Group with Oxfordshire County Council hosting the Learning Disability element. The Clinical Commissioning Group makes contributions to the pool, which are then used to purchase healthcare services. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget

ADULTS WITH CARE AND SUPPORT NEEDS MEMORANDUM of ACCOUNT for the year ending 31 March 2022

	Total Contributions £'000
Partner Contributions	
Oxfordshire CCG	92,160
Oxfordshire CC Social & Community Services Directorate	97,040
Total Funding	189,200
Total Expenditure	189,200
Net (Under)/Overspend	0

Balance Sheet

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

	31 March 2022 £'000
CURRENT ASSETS	
Debtors - Amounts falling due within 1 year	
Other prepayments and accrued income	1,195
TOTAL CURRENT ASSETS	1,195
Creditors - Amounts falling due within 1 year	
Accruals and deferred income	-1,195
NET CURRENT ASSETS / (LIABILITIES)	0
Provisions for Liabilities & Charges	
TOTAL ASSETS EMPLOYED	0
FINANCED BY:	
TAXPAYERS' EQUITY	
Reserve	0
TOTAL TAXPAYERS' EQUITY	0

18 Related party transactions

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:
• NHS England;
• NHS Foundation Trusts;
• NHS Trusts;
• NHS Litigation Authority and,
• NHS Business Services Authority.

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

During 2021-22, as a prerequisite of the ICS, Buckinghamshire, Oxfordshire and Berkshire West CCG's have been meeting in common as decision making forums covering Finance, Audit and Governing Body. All Executive members of each CCG attend and are members of these In Common meetings. Additional responsibilities are given to Robert Parkes, Non-Executive Director of Buckinghamshire to act as Convener of the Audit in Common meetings and Duncan Smith, Non-Executive Director of Oxfordshire CCG to act as Convener of the Finance in Common meetings.

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

Related Party	Payments to Related Party	Amounts owed to Related Party	Receipts from Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	4,707	0	0	0
NHS BUCKINGHAMSHIRE CCG	1,554	247	846	23
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	583,801	160	56	26
PRINCIPAL MEDICAL	3,323	76	0	0
ROYAL BERKSHIRE NHS FOUNDATION TRUST	29,062	75	0	0
SEOX Ltd	210	0	0	0
NHS BERKSHIRE WEST CCG	1,254	70	400	0
ST LUKE'S HOSPITAL	51	114	0	0
AGE UK OXFORDSHIRE	245	9		0
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	6,301	30	-30	0
OXFORDSHIRE COUNTY COUNCIL	108,674	5,567	14,191	1,873
SUMMERTOWN HEALTH CENTRE	1,690	1	0	0
WOODLANDS MEDICAL CENTRE	1,629	0	0	0
GORING & WOODCOTE MEDICAL PRACTICE	2,113	0	0	0
HOLLOW WAY MEDICAL CENTRE	1,125	10	0	0
ISLIP MEDICAL PRACTICE	10	0	0	0

18 Related party transactions cont'd

Name	Current position(s) held in the CCG	Relationship	Related Party
Dr Ansaf Azhar	Director of Public Health for Oxfordshire (non-voting)	Pooled budgets with NHS	OCC Pooled Budgets
Wendy Bower	Lay Member Patient and Public involvement (PPI) (Voting)	Director	Moneymaximer Ltd
		Governor	CCG Federation at RBFT
		Brother is Clinical Trials Specialist	Quintiles
		Daughter is employed by RBFT	Royal Berkshire NHS FT (RBFT)
		Employed by RBFT to provide clinical and staff support pre and during the COVID-19 Pandemic	Royal Berkshire NHS FT (RBFT)
		Lay Member Patient and Public Engagement	NHS Berkshire West CCG
Dr Ed Capo-Bianco	Portfolio Clinical Director	GP Partner	Goring & Woodcote Medical Practice
		Wife Salaried GP	Woodlands Medical Centre
		Practice Shareholder	Principal Medical Ltd
		Practice is a member	SEOX GP Federation
		Director	Red Kite Shop Ltd
		Practice is a member	Primary Care Network
Stephen Chandler	OCC Director of Adult Services (non-voting)	Pooled budgets with NHS	OCC Pooled Budgets
Dr David Chapman	Clinical chair (voting)	Property owning partner	Hollow Way Medical Centre
		Practice is a member of OxFED; Practice Partner is a Director of OxFed	OxFED
		Wife is an Advisor Manager	Oxford Citizens Advice Bureau
		Director	Kays Electronics Ltd
		Practice is a member of OPCN09 SEOxHA	Primary Care Network
Jo Cogswell	Director of Transformation	None	None
Heidi Devenish	Practice Manager Representative (non-voting)	Business Practice Manager	Summertown Health Centre
		Husband is Director of Pharmacy & Medicines Optimisation, Associate Deputy Director for Diagnostics and Outpatients Division, Trust Controlled Drug Accountable Officer	Great Western Hospital NHS Foundation Trust
		Member	Orchard Grove (Yarnton) Management Ltd
		Practice is a member of OPCN08 Healthier Oxford City Network	Primary Care Network
Dr Sam Hart	Network Clinical Director	GP Partner	Islip Medical Practice
		Champion for Parkrun (Islip is a Parkrun Practice, SH is nominated GP)	Parkrun
		Practice is a member of OPCN04 Kidlington, Islip, Woodstock and Yarnton (KIWY)	Primary Care Network
		Medical Referee paid to verify administrative details of people due for cremation; paid by Memoria who own crematorium	North Oxford Crematorium
Dr Shelley Hayles	Portfolio Clinical Director	Employee	Thames Valley Cancer Alliance
Diane Hedges	Deputy Chief Executive and Chief Operating Officer (non-voting)	Managing Director	Diane Hedges Ltd
Dr James Kent	Accountable Officer and Executive ICS Lead Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System	Wife is employed as a senior Pharmacist	Hall Practice and Chalfonts PCN
		John Storey, Porthaven Chief Executive, is a friend	Porthaven
		Director	Curzon Partners Ltd
Gareth Kenworthy	Director of Finance (voting)	Director	Oxfordshire Infracare LIFT
		Member of the Council of Governors	Oxford University Hospitals NHS Foundation Trust
		2 day per week secondment as ICS Finance Lead	Integrated Care System (ICS)
		Spouse is employed as an activity co-ordinator. OCCG has a contract for care services with St Luke's	St Luke's Hospital
Catherine Mountford	Director of Governance and Business Process (non-voting)	Daughter works on the Oxford University Hospitals NHS Foundation Trust Helpdesk	Bouygues UK
Robert Parkes	Lay Member Governance	Responsible financial officer	Chearsley Parish Council
		Lay Member, Lay Vice Chair, Chair of Audit Committee	NHS Buckinghamshire CCG
Dr Meenu Paul	Assistant Clinical Director Quality, Clinical Lead for Medicines	GP locum (sabbatical during 2018/19)	GP Practices across Oxfordshire
		Sister works for the company	Abbvie Pharmaceuticals
Guy Rooney	Medical Specialist Advisor (voting)	Member	Thames Valley Clinical Senate
		Consultant	Great Western Hospital NHS Foundation Trust
		Medical Director	Oxford Academic Health Science Network (AHSN)
		Steering Group Member	NHS Benchmarking Network
Duncan Smith	Lay Member (voting)	Wife is employed by the Trust	Avon and Wiltshire Parternship Mental Health
Dr Andy Valentine	Network Clinical Director	Salaried GP	Dr Leaver and Partners
		Wife employed as an anaesthetist	Royal Berkshire Hospital
		Practice is a member of OPCN07 Oxford Central	Primary Care Network
		PCN Clinical Director	Practice is a member of OPCN07 Oxford Central
Sula Wiltshire	Registered Nurse on the Governing Body (Board) (voting)	Daughter is employed as a Nurse	Oxford University Hospitals NHS Foundation Trust

18 Related party transactions cont'd - to be updated

Oxfordshire CCG Practices	Total £
ABINGDON SURGERY	1,898,906
BAMPTON MEDICAL PRACTICE	1,130,066
BANBURY HEALTH CENTRE	32,100
BANBURY ROAD MEDICAL CENTRE	845,091
BARTLEMAS SURGERY	1,670,349
BEAUMONT STREET SURGERY	602,380
BELL SURGERY	1,249,910
BERINSFIELD HEALTH CENTRE	201,289
BICESTER HEALTH CENTRE CONSORTIUM	15,114
BLETCHINGTON ROAD SURGERY	1,673,479
BLOXHAM & HOOK NORTON SURGERIES	1,671,761
BOTLEY MEDICAL CENTRE	1,768,649
BROADSHIRES HEALTH CENTRE	1,245,804
BROOK & CHILTERN SURGERY (THE)	7,113
BURY KNOWLE HEALTH CENTRE	4,057,123
CHARLBURY MEDCIAL CENTRE	849,903
CHILTERN SURGERY	1,065,716
CHIPPING NORTON HEALTH CENTRE	3,226,286
CHURCH STREET PRACTICE	2,165,429
CLIFTON HAMPDEN SURGERY	10,306
COGGES SURGERY	936,790
COKER CLOSE HEALTH CENTRE	2,218,513
COWLEY ROAD MEDICAL PRACTICE	2,595
CROPREDY SURGERY	1,160,309
DEDDINGTON HEALTH CENTRE	24,884
DIDCOT HEALTH CENTRE	2,196,574
DONNINGTON MEDICAL PARTNERSHIP (THE)	1,554,285
DR A MURPHY & PARTNERS	2,175,504
DR B J BATTY & PARTNERS	169,762
DR BRYSON & PARTNERS	69,333
DR HAMMERSLEY & PARTNERS OXFORD	697,582
DR KENYON & PARTNERS	1,557,785
DR T W ANDERSON & PARTNERS	2,239,674
EARLS LANE HEALTH CENTRE	2,614,955
EAST OXFORD HEALTH CENTRE STEVENS	1,420,050
EYNSHAM MEDICAL CENTRE	2,793,864
FANE DRIVE HEALTH CENTRE	587,478
GORING & WOODCOTE MEDICAL PRACTICE	2,113,188
GOSFORD HILL MEDICAL CENTRE	876,038
HART SURGERY	1,354,809
HIGHTOWN SURGERY	1,385,105
HOLLOW WAY MEDICAL CENTRE	1,124,793
HORSEFAIR SURGERY	1,630
ISLIP MEDICAL PRACTICE	9,751
JERICHO HEALTH CENTRE KEARLEY	1,261,118
JERICO HEALTH CENTRE BOGDANOR	795,781
KEY MEDICAL PRACTICE	1,480,181
KING EDWARD STREET SURGERY	492,235
LEYS HEALTH CENTRE	1,997,817
LONG FURLONG MEDICAL CENTRE	998,804
LUTHER STREET MEDICAL CENTRE	8,225
MALTHOUSE SURGERY	2,124,864
MANOR SURGERY	2,135,376
MARCHAM ROAD HEALTH CENTRE	2,666,154
MILL STREAM SURGERY	703,229
MONTGOMERY-HOUSE SURGERY	140,078
MORLAND HOUSE SURGERY	2,376,842
NETTLEBED SURGERY	1,161,782
NEWBURY STREET PRACTICE	1,894,225
NUFFIELD HEALTH CENTRE	2,876,135
OAK TREE HEALTH CENTRE	1,129,266
OBSERVATORY MEDICAL PRACTICE	2,860
RYCOTE PRACTICE	1,343,715
SHEEP STREET SURGERY BURFORD	1,199,484
SIBFORD SURGERY	616,463
SONNING COMMON HEALTH CENTRE	1,530,425
ST BARTHOLOMEWS MEDICAL CENTRE	2,934,360
ST CLEMENTS SURGERY OXFORD	482,928
SUMMERTOWN HEALTH CENTRE	1,689,861
TEMPLE COWLEY HEALTH CENTRE	1,019,804
WALLINGFORD MEDICAL PRACTICE	2,594,303
WATERY LANE SURGERY	844,857
WEST BAR SURGERY	4,896,424
WHITE HORSE MEDICAL CENTRE	3,219,917
WHITE HORSE PRACTICE	161,808
WINDRUSH MEDICAL PRACTICE WITNEY	2,988,893
WINDRUSH SURGERY BANBURY	1,090,544
WOODLAND SURGERY BANBURY	889,205
WOODLANDS MEDICAL CENTRE	1,628,543
WOODSTOCK SURGERY	1,325,263
WYCHWOOD SURGERY	1,172,305

Oxfordshire CCG PCN	Payment to PCN £
ABINGDON SURGERY PCN	517,224
BANBURY ALLIANCE PCN	658,696
BANBURY TOWN PCN	2,681,785
CHURCH STREET PCN	645,941
GORING & WOODCOTE MEDICAL PRACTICE PCN	581,881
HENLEY SONNET PCN	740,412
NORTH OXFORDSHIRE PCN	1,297,742
OAK TREE HEALTH CENTRE PCN	898,484
OXFORD CENTRAL PCN	524,729
PCN WHITE HORSE BOTLEY	784,613
RURAL WEST PCN	555,795
THAME PCN	674,883

19 Events after the end of the reporting period

On 28 April 2022, the Health and Care Act 2022 received Royal Assent. As a result, Clinical Commissioning Groups will be abolished and the functions, assets and liabilities of Oxfordshire CCG will transfer to Buckinghamshire,Oxfordshire and Berkshire West Integrated Care Board from the 1 July 2022. This constitutes a non-adjusting event after the reporting period. This does not impact the basis of preparation of these financial statements.

20 Financial performance targets

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

	2021-22 Target	**2021-22 Performance**	**Duty Achieved?**	2020-21 Target	2020-21 Performance	Duty Achieved?
Expenditure not to exceed income	1,283,407	1,283,316	Yes	1,088,564	1,088,329	Yes
Capital resource use does not exceed the amount specified in Directions	-	-	N/A	40	40	Yes
Revenue resource use does not exceed the amount specified in Directions	1,279,418	1,279,327	Yes	1,087,059	1,086,823	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	N/A	-	-	N/A
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	N/A	-	-	N/A
Revenue administration resource use does not exceed the amount specified in Directions	13,160	12,921	Yes	13,172	12,854	Yes

For the purposes of this note expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and, income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).