NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Annual Report 1 April – 30 June 2022

Contents

Performance Report

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

The following performance report consists of a performance overview and a performance analysis. It outlines what Oxfordshire Clinical Commissioning (OCCG) was; its purpose, statutory duties and how the OCCG executed those duties between 1 April to the end of June 2022 before it was dissolved on 30 June 2022. It looks at the work of OCCG, how the organisation performed over the last few months of its existence and outlines the risks it faced.

Performance Overview

NHS Oxfordshire Clinical Commissioning Group (OCCG) was the statutory organisation in Oxfordshire that planned, bought and oversaw health services for more than 770,000 people from a range of NHS, voluntary, charitable, community and private sector providers until the end of June 2022 when it was abolished and its functions transferred to Buckinghamshire, Oxfordshire & Berkshire West Integrated Care Board.

OCCG was 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 were 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 was a member organisation of 67 GP practices in Oxfordshire; it worked 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).

Before being abolished at the end of June 2022 to make way for the establishment of Integrated Care Boards, OCCG was part of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) which covers a population of 1.8 million, previously three Clinical Commissioning Groups (CCGs), 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 Act 2022 put Integrated Care Systems on a statutory footing from 1 July 2022, empowering them to better join up health and care services, improve population health and reduce health inequalities.

Each ICS includes an NHS Integrated Care Board (ICB), for our area this is the Buckinghamshire, Oxfordshire and Berkshire West Integrated care Board (BOB ICB). This new organisation has responsibility for NHS functions and budgets, also being developed is an Integrated Care Partnerships (ICP), a statutory joint committee of the BOB ICB and five local authorities responsible for adult social care bringing together all system partners to produce a health and care strategy.

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

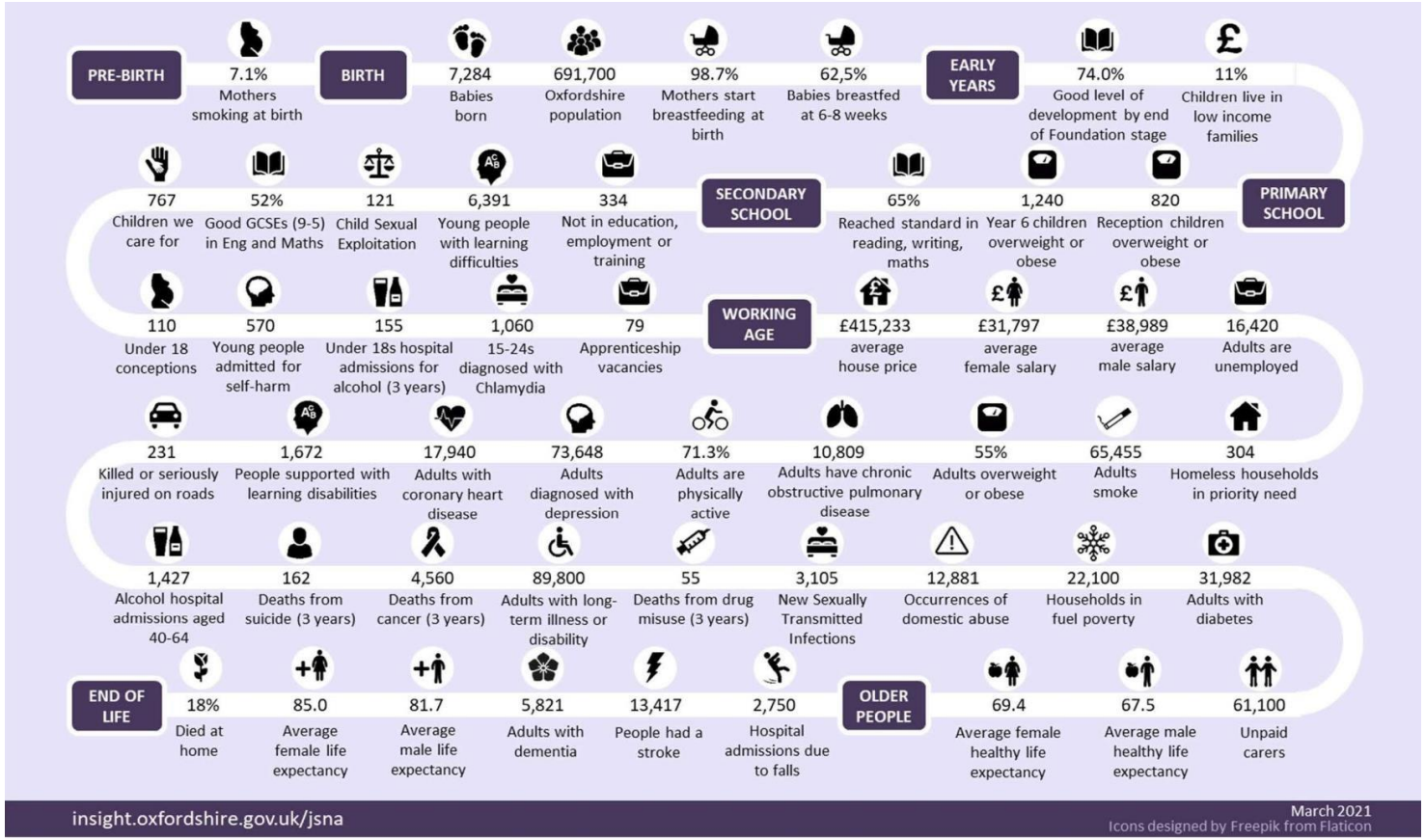
the people of Oxfordshire; board members include local GPs, senior Councillors, Healthwatch Oxfordshire and senior officers from the NHS and Local Government.

OCCG had 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 carried out these duties from 1 April to 30 June 2022 before it was abolished.

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 3.

Performance Analysis

Overview Steve McManus, Accountable Officer

Not much time has passed since I last wrote an overview for OCCG's Annual Report 2021/22; April to the end of June 2022, saw much work continuing from last year alongside preparations to close down the three BOB CCGs and establish a new Integrated Care Board for Buckinghamshire, Oxfordshire and Berkshire West (BOB ICB).

I want to take the time to celebrate the success of OCCG; a major achievement in recent years was the delivery of the COVID-19 vaccination programme. 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. At the end of June 2022, we had delivered1,666,449 vaccines across Oxfordshire including offering vaccinations to all 5 -11-year-olds, and a second 'booster' jab to those aged 75. Huge thanks go to the thousands of people across the NHS, local authorities and volunteers who contributed to this success.

Other successes include the award-winning suspected cancer (SCAN) pathway work and improvements in the diabetes pathway. OCCG and OUHFT won Cancer Care Team of the Year at The British Medical Journal Awards 2020 for the innovative suspected cancer (SCAN) two-week pathway run at the Churchill Hospital in Oxford. The SCAN two-week pathway was specifically designed for patients with "low risk but not no risk" cancer symptoms. Patients are referred to the service by their GP if they have symptoms such as unexplained fatigue or unintended weight loss. If they meet the SCAN pathway criteria, they undergo a CT scan and blood tests. If cancer is detected, they are referred to the appropriate consultant so they can start treatment quickly.

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

In 2012/13 OCCG undertook an extensive process to engage users, carers, clinicians and providers in exploring the rationale for outcomes-based commissioning and in designing both those outcomes that would make a difference to people living with mental illness, and the model for delivering this new kind of service. An outcomes-based contract was awarded to Oxford Health as a result, and they work, as a lead provider with Restore, Oxfordshire Mind, Response, Connection Support and Elmore Community Service as part of the Oxford Mental Health Partnership to deliver mental health services that aim to achieve outcomes designed by clinicians, patients and members of the public. This partnership and the work they have been delivering has won many awards including the Excellence for Mental Health Care category in the 2019 NHS Parliamentary Awards in recognition of the partnership's pioneering approach to mental health care.

In primary care considerable developments have been made including improvements to premises for GP practices in Oxford city with the new builds of New Radcliffe House and Northgate; both premises offer modern and spacious health centres in the heart of Oxford. In recent years, the development of 20 Primary Care Networks has been a real achievement for Oxfordshire. The NHS Long Term Plan set an ambitious programme of change for primary care and community services and Oxfordshire rose to the challenge. Primary Care Networks are based around a GP registered list of approximately 30,000 – 50,000 patients, including GP practices and other partners in community and social care. The networks offer services on a scale that is small enough for patients to get the continuous and personalised care they value, but large enough – in their partnership with others in the local health and care system - to be resilient and sustainable.

As well as recognising the achievements of OCCG, I also want to extend my gratitude to colleagues within the organisation; during the time of the CCG and especially the past couple of years many have worked above and beyond, working in different ways, in different roles and during organisation change which has gone on for quite some time.

As we have now moved into a new organisation, I am encouraged to see colleagues embrace the new BOB ICB and rise to the challenges facing the entire system across BOB. This puts us in a very good place to progress work and develop health and care services to benefit our local population.

Improving the health and wellbeing of people in Oxfordshire

The H&WB board continues to provide 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 the 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 was 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 are included from a wide range of sources and provide 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 ongoing COVID-19 pandemic has hampered delivery.

Buckinghamshire, Oxfordshire and Berkshire West ICS delivery of the COVID-19 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 focus of the vaccination programme work during the period 1 April to 30 June 2022 was the spring booster campaign. Working across the BOB ICS, an 85.8 per cent vaccination rate was achieved across the most vulnerable patient groups (over 75s and care home residents) compared with the national average of 82.8 per cent.

In addition, the ICS tried to build on the success of the COVID-19 vaccination inequalities outreach programme by extending this to include an 'all vaccinations' approach and joint working with regional public health teams. The programme focused on the spring boosters and evergreen offer, but more importantly promoting a *'Making Every Contact Count'(MECC)* [2]approach. This was particularly successful in vulnerable and hard-to-reach groups where there was, and continues to be, an opportunity to talk to people about other aspects of health and wellbeing.

Vaccination of 5–11-year-olds came at the end of the programme and although not seen as essential by many, BOB achieved higher than average vaccination rates by working with Oxford Health as a lead provider and vaccinating at family centres in the heart of local communities. This work achieved a vaccination rate of 38.5 per cent which placed the BOB ICS in the top five nationally. For vaccination of 12-15-year-olds, the BOB ICS remains top in the country thanks to the schools' immunisation teams and lead provider follow-up clinics.

More than four million vaccinations have been given across the BOB population of 1.8 million since the start of the programme in December 2020. Vaccination remains open to all and continues to be promoted, providing an evergreen offer that means people can always get first, follow-up, or booster doses.

By the end of June 2022 in Oxfordshire:

- 1,666,449 vaccines had been delivered
- 265,023 50-year-olds and over had received two doses
- 253,150 50-year-olds and over had received their booster
- 66,038 of our 75-year-olds and over had received their 2nd booster (4th vaccine) even though the 2nd booster programme had only commenced 21 March
- 457,273 of those 18-year-olds and over had received their booster (3rd vaccine)
- For 12-15 year-olds 22,860 had received a 1st dose and 16,464 a 2nd
- For 5–11-year-olds 9,491 had received a 1st dose and 591 a 2nd

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

[2] MECC is an approach to behaviour change that you can use in day-to-day conversations with patients and the public. Opportunistic interactions that help encourage positive changes to their physical and mental health and wellbeing.

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, this is similar across the country. As such key area of focus during April – June 2022 continued to be supporting 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 patients and reduce waiting times

In June, it was announced nationally that the number of people on the waiting list for diagnostic tests had dropped and there were two-thirds fewer people waiting more than two years for elective care. While hospital Trusts across BOB continue to experience larger waiting lists compared to pre-COVID levels (Royal Berkshire Hospitals NHS Foundation Trust seeing the largest increase of 48%, OUHFT at 22% and Buckinghamshire Healthcare Trust at 18%) the number of people waiting over 52-week waits is slowly reducing.

The focus of elective recovery during April to June has been to treat all patients waiting greater than 104 weeks and apart from a small number of complex patients this has been achieved across BOB. Substantial progress has been made on reducing 78-week waiters across BOB and we are currently ahead of trajectory and we are aiming to have no patients waiting longer than 78 weeks by 31 December 2022.

Work also continued to deliver the BOB Elective Recovery Programme including progressing the introduction of a systemwide referral management solution starting in Ear, Nose and Throat (ENT) and Ophthalmology to provide a single point of access, unified primary care pathways, reduce outpatient demand, monitor and identify bottlenecks and enable wider service redesign. Throughout April to June 2022, we continued to work with providers in the Independent Sector to secure capacity and help reduce waiting times.

Cancer services

Like other health service areas, cancer services across the country have continued to 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[3] 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.

The BOB CCGs along with Trusts across the system set out to achieve the target of returning the number of people waiting 62 days or more for cancer treatment to the February 2020 level (plans reduce the waiting list to 360 against a target of 366). This position has proved extremely challenging during April to June 2022 with the latest BOB system position of 869 patients waiting over 62 days. This equates to over 11% of the total waiting list. During this time key workstreams have been set up to support the delivery of improvement across all cancer standards which include:

- Extending coverage of non-specific symptom (NSS) pathways
    - Although we are below plan in this area, we are the highest performing system within the South East Region with more than double the NSS referrals of the nearest ICB.
- Timely presentation and effective primary care pathways
- Best practice timed pathways
- Priority pathway improvement – FIT (Faecal Immunochemical Test) testing and skin pathway redesign
- Targeted case finding and surveillance – Targeted lung health checks, Lynch Syndrome, Liver Surveillance
- Population Screening

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.

Urgent and emergency care continued to be extremely pressured during April to June 2022 and was impacted in this quarter by increased

[3] Data from December 2021

COVID rates and staff sickness.

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 continued to work 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 the hospital, please talk to us. We will always support people to get home with the appropriate care packages.

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 was undertaken during 2021/22 to help alleviate pressures and improve patient flow through the county's hospitals and this continued through April-June 2022. In Oxfordshire, a new Urgent Care Centre (UCC) opened as a pilot, initially for three months, at the Fiennes Centre at the Horton General Hospital to help improve patient outcomes, as well as to ease the pressure on health and care services. Principal Medical Limited (PML) and Oxford Health have worked together to provide this service from 8am until 10pm, seven days a week. The service is by referral only, not walk-in; the main sources of referrals to the UCC were from the Horton General Hospital Emergency Department (HGH ED), Primary Care, and NHS 111. All the referrals from the HGH ED and Primary Care had face-to-face assessments, and many of the NHS 111 referrals were managed over the telephone. Seventy one percent of patients were discharged with no further care required. Children who required a paediatric opinion were either seen in the Children's Ward on the HGH site or the paediatrician reviewed the child in the UCC.

During Q1 work continued, across the BOB ICS, with the development of virtual wards to support patients, who would otherwise be in hospital, to receive the acute care, remote monitoring, and treatment they need in their own home or usual place of residence. This is an ambitious programme to reduce hospital admissions and support the timely discharge of patients from the hospital; the national ambition is to have 40–50 virtual beds per 100,000 population.

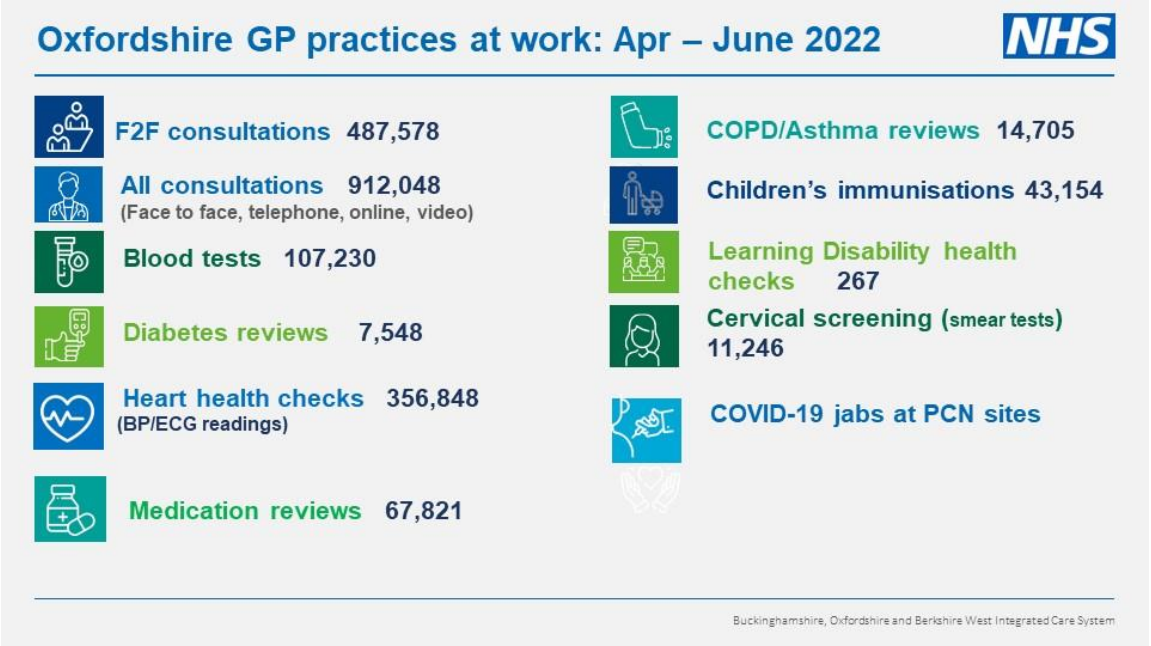
General Practice Services

Since the start of the pandemic many changes were made to the way health services were accessed and delivered; much of this has continued. In Primary Care rapid changes were made to reduce face-to-face contact which in turn reduced the risk of spreading the infection.

A key feature and point of difference during the pandemic were the 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 to leave home for a face-to-face appointment. For patients with the relevant technology, appointments have been available using video conferencing with healthcare professionals.

While this way of working has continued; 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.

Below outlines the different areas of work undertaken in general practice between 1 April to 30 June 2022, while also continuing to deliver the COVID-19 Vaccination Programme.



Patient satisfaction was maintained despite the challenges faced by our practices, such as staff sickness and the requirement to redirect resources to the accelerated Covid booster vaccination programme. The latest GP Patient Survey which is an England-wide survey, providing data about patients' experiences of their GP practices, is available here. In BOB 53,363 questionnaires were sent out, and 17,933 were returned completed representing a response rate of 34%. It showed that 75% of respondents felt their experience with the GP practice was good compared to the national average of 72%.

Delivery of mental health services

Throughout the past year and continuing into April to June 2022 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.

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.

To gain greater oversight of progress across Mental Health services, it has been agreed to construct two governance streams separating transformation from performance and assurance reporting for the ICB, which will be developed further from July 2022. TOR (Terms of Reference) and a Governance framework have been established, with clear system responsibilities, accountabilities and reporting arrangements agreed.

During April to 30 June:

Children and young people's mental health services (CYP): Work has begun to ensure consistent and transparent reporting of referral rates, waiting times and activity in delivery, with a focus on clarifying capacity, demand, and service activity across the system.

Eating Disorders: Progress has been made to address recruitment challenges in the workforce teams for eating disorders. Innovative recruitment approaches have led to an increase in workforce capacity.

Improving Access Psychological Therapies: An IAPT (Improving Access to Psychological Therapies) recovery plan has been developed to improve access. A transformation programme is now in place and a marketing campaign has begun to drive referrals for people from Black, Asian, and minority ethnic communities and older people.

Dementia Diagnosis Rate (DDR): A plan has been developed for improving DDR by in reaching into care homes.

Mental Health Practitioner roles: Recruitment is taking place across all PCNs to establish Mental Health Practitioner roles, through the Additional Roles Reimbursement Scheme (ARRS) to ensure clinical expertise for Mental Health is developed across our primary care services.

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 needs, and Integrated Care System (ICS) opportunities.

This plan was developed across system partners to meet the emerging needs of the local and ICS population; it outlines how patient 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 drove this agenda with their local partners and delivered their own initiatives throughout the year.

In April 2022, the BOB ICS moved into the second year of the Learning Disabilities and Autism three-year delivery plan, building on the notable achievement of 73 per cent of annual health checks completed. This demonstrates continued efforts in reducing health inequalities for people with a learning disability.

BOB has further agreed on four priorities for 2022/2023 to continue reducing the numbers of people admitted into hospitals and improving the quality of care for inpatients; developing a more robust support model for autistic people; creating a better transition for young people moving into adulthood; and improving health equality by building on the success of annual health checks and health action plans. This work will be driven by the BOB ICB from July in continued collaboration with partners across the system.

Medicines Optimisation

The safe and effective use of medicines is an essential element of healthcare. The aim of the CCG Medicines Optimisation (MO) teams has always been to support clinicians, patients and carers in making decisions about which medications to use to get the best possible outcomes.

From April to June 2022, the three MO teams across the BOB moved to a whole team structure ahead of the formation of the ICB on 1 July to maximise individual expertise and minimise duplication. A BOB-wide Area Prescribing Committee was established, and a BOB-wide Prescribing Quality Scheme has been developed ready for rollout in the summer of 2022.

Strong links with colleagues working in PCNs continued, with further joint projects across BOB, including the drafting of an Induction Pack for practice-based pharmacy staff and the review of possible joint roles across PCNs and secondary care. In addition, continued collaborative work with the Local Pharmaceutical Committees (LPCs) ensured that schemes commissioned from community pharmacies could become BOB-wide.

In Oxfordshire, the 2021/22 Prescribing Incentive Scheme was extended to the end of June, due to the ongoing COVID pandemic and focused on quality initiatives, including the review of prescribing of high-risk medicines, antimicrobials and the treatment of heart failure. The Prescribing Dashboard on the OCCG website informed practices on prescribing targets, achievements and priorities.

Improving Quality

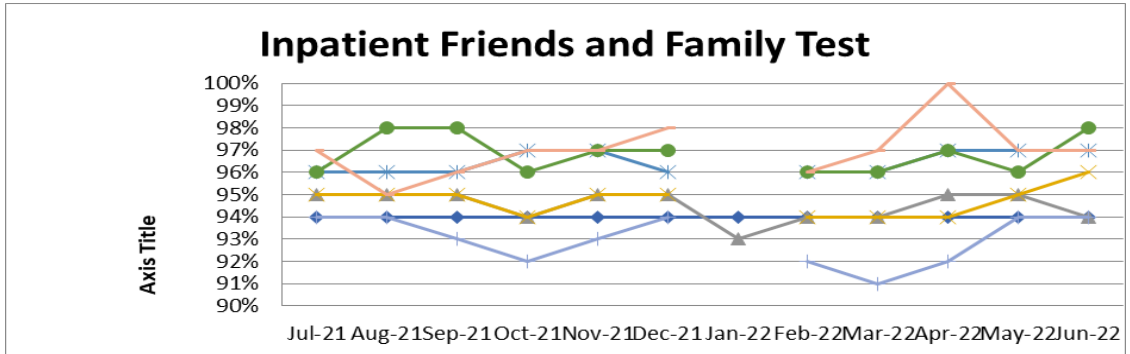
OCCG was responsible for ensuring continuous improvement in the quality of services it commissioned in connection with the prevention, diagnosis, or treatment of illness. Quality is defined in the NHS as safe and effective care alongside outstanding patient experience. Improving the quality of healthcare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

OCCG worked together with partners to improve patient experience, improve the quality of services and learn from incidents to reduce the risk of

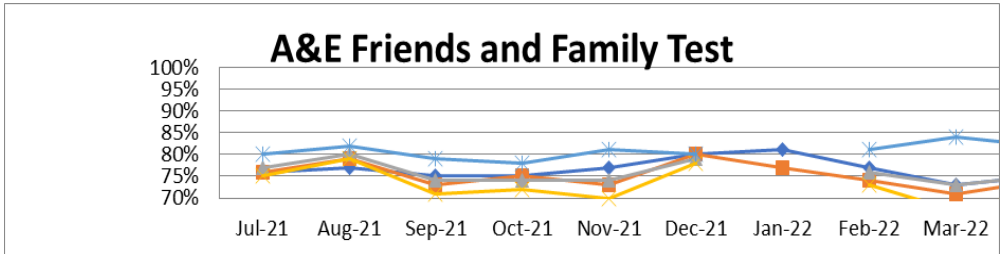
them happening again.

Part of this quality monitoring included OCCG collecting feedback from members of the public about their experiences of healthcare through compliments and complaints and patient experience surveys. OCCG received 11 formal complaints between 1 April to 30 June 2022. No complaint was referred to the Ombudsman.

OCCG monitored 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 of inpatient services and A&E at OUHFT.



	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
England	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%
BOB	95%	95%	95%	94%	95%	95%	93%	94%	94%	95%	95%	94%
OUHFT	95%	95%	95%	94%	95%	95%		94%	94%	94%	95%	96%
Churchill Hospital	96%	96%	96%	97%	97%	96%		96%	96%	97%	97%	97%
Horton Hospital	96%	98%	98%	96%	97%	97%		96%	96%	97%	96%	98%
John Radcliffe	94%	94%	93%	92%	93%	94%		92%	91%	92%	94%	94%
NOC	97%	95%	96%	97%	97%	98%		96%	97%	100%	97%	97%



	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
England	76%	77%	75%	75%	77%	80%	81%	77%	73%	75%	75%	74%
BOB	76%	79%	73%	75%	73%	80%	77%	74%	71%	74%	72%	73%
OUHFT	77%	80%	74%	74%	74%	79%		76%	73%	75%	74%	75%
John Radcliffe	75%	79%	71%	72%	70%	78%		73%	67%	72%	71%	72%
Horton Hospital	80%	82%	79%	78%	81%	80%		81%	84%	82%	79%	81%

Oversight of quality was 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 was chaired by the Medical Specialist Advisor from the OCCG Governing Body and included 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.

In line with the significant changes to patient safety, via the Patient Safety Strategy and the new Patient Safety Incident Response Framework, a BOB-wide Patient Safety Specialist Forum has been established to support closer working between providers to learn from Patient Safety Incidents.

OUHFT reported to the Oxfordshire Quality Committee on progress against a long-standing quality challenge – the safe endorsement of test results. The Trust held a summit to review the extent of the issue and address the factors underpinning the challenge and has demonstrated an improvement in this area which it is hoped will be sustained.

Addressing health inequalities

Work continues across the BOB ICS to reduce health inequalities; in the past year, a BOB-wide equalities group was established to identify inequalities and implement evidence-based interventions to reduce the gaps by working with local communities and ensuring learning is shared on best practices 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.

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 examples of outreach work in Oxfordshire are outlined below:

Visit to Banbury's Madni Masjid (Mosque) in May 2022: OCCG Equality and Access Team and partners (OH nurses and social prescribers from Banbury Cross Health Centre) visited Banbury's Madni Masjid (Mosque) in the 'Health on the Move' mobile clinic to deliver COVID 1st/2nd and booster jabs and to raise awareness of local health services in Oxfordshire.

Two visits to the Sheikh Abdul Aziz Ibn Baaz (Mosque) in Banbury: OCCGs Equality and Access Team visited the Sheikh Abdul Aziz Ibn Baaz (Mosque) in Banbury to raise awareness among the community of local health services, including cancer screening, stop smoking initiatives and diabetes prevention. The team showed the community how to check their blood pressure to know if they are at risk of serious illness and distributed several blood pressure kits and oximeters among the community.

Meeting the Ukrainian community in Bicester: OCCGs Equality and Access Team met with members of the Ukrainian community in Bicester in July 2022 to raise awareness about local health services. The visit was part of a wider initiative by the local NHS to meet communities and groups in Oxfordshire to promote health equality.

Engaging the public and local communities

The CCGs across BOB were committed to continuously strengthening public participation in all areas of work. However, progressing this throughout the pandemic 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.

April to the end of June 2022 was spent developing a new strategy for how the developing BOB ICB would work with people and communities in line with the published guidance available here. An initial draft was developed following some early discussion with the five Healthwatches across Buckinghamshire, Oxfordshire and Berkshire West, lead governors from hospital Trusts and the VCSE alliance. A period of engagement was also undertaken with the public; the draft strategy was shared and comments/feedback were received. The feedback received on the approach to engagement shared in the draft strategy, including input from the BOB Health and Wellbeing Boards and Overview and Scrutiny Committees has informed the updated strategy being presented to the ICB Board in September 2022.

Developing a sustainable environment

As part of the BOB ICS, OCCG was 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 carbon net 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.

Between April to the end of June 2022, OCCG as part of the BOB ICS continued its efforts and commitment to delivering against the NHS Green Plan, the BOB ICS has now developed the Sustainability Forum alongside the Net Zero Programme Board which oversees the implementation of Sustainable

and Net Zero initiatives. The forum aims to bring together people from across the ICS to share the work already happening towards sustainability, allowing expansion and development of further initiatives, sharing funding opportunities, and collaboration on new and existing projects. Additionally, it is hoped to identify Green Champions within this Forum, who have a passion for Sustainability and who will work to create new ideas and get others involved. The goal is to embed sustainability into all aspects of NHS working.

Funding applications have recently been submitted to the 'Healthier Futures Action Fund' for three new projects. One Menu is an effort towards creating a universal menu to be served across all BOB hospitals from locally sourced ingredients. The initial pilot will take place in Buckinghamshire Healthshare Trust hospitals and, if successful, will be implemented across BOB.

The second project aims to investigate the carbon footprint of paper prescriptions. The investigation will focus on the waste produced by the prescription process, specifically with repeat prescriptions, with a view to improving these numbers by educating the public.

The Electric Bikes project aims to provide Electric Bikes to the Community Nurses based in Oxford City to help remove cars from roads, improving air quality and carbon emissions, and will benefit the nurses who will no longer require their own vehicles.

In Oxfordshire the Littlemore Mental Health Centre in Oxford has teamed up with Earthwatch Europe and is further supported by Oxford University's Green Templeton College and MINI Electric, to create a 'Tiny Forest'. This tennis court-sized patch of land which has been planted with fast-growing, native trees to create a dense woodland. The project will improve the environment for patients at the site, creating a calm atmosphere; reduce carbon emissions to support efforts towards Net Zero; and promote biodiversity.

Responding to an emergency

Under the Civil Contingency Act 2004, CCGs were designated Category Two responders and had a duty to co-operate and share information in an emergency. As a Category Two responder, OCCG had 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 was 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 were required to have an Accountable Emergency Officer who can take executive responsibility for leadership for EPRR. The OCCG Director of Governance held this executive responsibility for all three BOB CCGs. A 24/7 director on-call rota was in place to deal with any issues escalated to us by providers and 24/7 communications on-call rota exists for media and communications issues.

OCCG had incident response plans in place which are compliant with the NHS England Emergency Preparedness Framework 2013. OCCG regularly reviewed and made improvements to its major incident plan and had 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 couple of 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 developed to strengthen the response arrangements to increase resilience and effectiveness across the three counties.

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. From May 2022 the three CCGs implemented a single two-tier director on-call rota in preparation for the establishment of the ICB.

NHS England has published NHS core standards for EPRR arrangements. These are the minimum standards that 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.

How does OCCG manage its money?

Oxfordshire CCG (OCCG) was in existence from 1st April 2022 to 30th June 2022 after which it ceased to be a legal body and its assets and liabilities were transferred to the newly created Integrated Commissioning Board covering Buckinghamshire Oxfordshire and Berkshire West (BOB ICB).

For the part financial year 2022/23, OCCG's total funding was £309.7m. Of this, £304.7m was allocated for healthcare programmes and £3.3m for the CCG's running costs as reflected in the table below which summarises our budget (plan) and actual expenditure for Q1 2022/23:

	Budget M1 to M3 £'000	Actual M1 to M3 £'000	Variance M1 to M3 £'000
Acute	159,418	159,685	268
Community Health	35,471	33,599	(1,872)
Continuing Care	17,273	17,135	(138)
Mental Health and Learning Disability	27,727	27,796	69
Delegated Co-Commissioning	29,396	29,355	(41)
Primary care	30,480	28,874	(1,606)
Other Programme	4,976	8,940	3,963
Sub Total Programme costs	**304,741**	**305,383**	**642**
Running costs	3,311	4,289	978
Sub Total CCG	**308,052**	**309,672**	**1,620**
Planned surplus/(deficit)	1,620	0	(1,620)
Total CCG	**309,672**	**309,672**	**0**

OCCG brought forward a cumulative historical surplus of £23.4m into 2022/23 none of which was requested to be utilised (drawn down) in the quarter. The historical surplus transferred to the BOB ICB and was offset against historical deficits transferred from Buckinghamshire and Berkshire West CCGs. The ICB started with an historical surplus of £1.5m.

OCCG has formal delegated responsibility from NHS England for GP Primary Care Commissioning and received an allocation of £29.4m in order to deliver this.

During the year, OCCG continued joint commissioning and pooled budget arrangements with Oxfordshire County Council (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 previous years.

The County Council and the CCG continued with the governance structure put in place on 1st April 2021 ie the Joint Commissioning Executive (JCE).

In line with national policy direction for the NHS, Oxfordshire CCG continued to work closely with Buckinghamshire and Berkshire West CCGs in the Quarter, as part of the wider Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS). BOB ICB became a statutory organisation from 1 July 2022.

Performance 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 the 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 Q1 2022/23 we have continued to make use of the available technology to enable our meetings to continue and our actions have been weighted towards the system response to the pandemic and as we move into recovery.

The system continues to be under significant pressure; this has been compounded by high level of demand during the winter months which continued into spring. 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 performance in Oxfordshire for April to the end of June 2022:

Group	Standard Description	Standard	April to 30 June 2022
Cancer	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	93%	66.5%
	Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected	93%	11.2%
	Percentage of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat')	96%	89.1%
	Percentage of patients receiving first subsequent treatment within 31-day, where that treatment is Surgery	98%	74.5%
	Percentage of patients receiving first subsequent treatment within 31-day, where that treatment is an Anti-Cancer Drug Regimen	94%	97.0%
	Percentage of patients receiving first subsequent treatment within 31-day, where	94%	87.3%

	that treatment is a Radiotherapy Treatment Course		
	Percentage of patients receiving first definitive treatment within two months (62 days) of an urgent GP referral for suspected cancer	85%	59.1%
	Percentage of patients receiving first definitive treatment within 62 days of referral from NHS Screening Service	90%	81.3%
	Percentage of patients receiving first definitive treatment within 62 days of a consultants decision to upgrade their priority status	86%	6.0%
RTT – Incomplete	Incomplete Pathways over 52 weeks at month end	Plans at ICB level. RAG rating as ICB total	1365
	Incomplete Pathways over 78 weeks at month end		185
	Incomplete Pathways over 104 weeks at month end		15
Mental Health	IAPT - Access Rate	6.25%	5.9%
	IAPT - Moving to Recovery	50%	51.7%
	Dementia Diagnosis Rate	67%	60.8%
C&YP Eating Disorders	CYP Eating Disorders - Urgent (1 week)	95%	58.5%
	CYP Eating Disorders - Routine (4 weeks)	95%	71.1%
Ambulance Response Times	Category 1 Incidents 90th Percentile	15:00	18:16
	Category 2 Incidents 90th Percentile	40:00	0:53:25
	Category 3 Incidents 90th Percentile	120:00	231:46
	Category 4 Incidents 90th Percentile	180:00	281:48

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 33). 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.

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 during 1 April to 30 June 2022 can be found on OCCG's website here.

Steve McManus
Accountable Officer
28 June 2023

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 comprised 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 Governing Body as of 30 June 2022 included:

- Ansaf Azhar, Corporate Director of Public Health, OCC
- Dr Ed Capo-Bianco, Urgent & Emergency Care Portfolio Clinical Director
- Wendy Bower, Lay member, PPI
- Stephen Chandler, Corporate Director of 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
- Diane Hedges, Deputy Chief Executive
- Gareth Kenworthy, Director of Finance
- Catherine Mountford, Director of Governance
- Dr Meenu Paul, Clinical Lead, Mental Health, Learning Disability

- Robert Parkes, Lay Vice Chair/Chair of the Audit Committee
- Dr Guy Rooney, Specialist Medical Advisor
- Duncan Smith, Lay Member for Finance
- Dr Andy Valentine, Oxford City Network Clinical Director

Statement of Disclosure to Auditors

Each individual who was a member of the CCG during April to 30 June 2022 confirmed:

- so far as the member was aware, there was no relevant audit information of which the CCG's auditor was unaware that would be relevant for the purposes of their audit report.
- the member had taken all the steps that they ought to have taken to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Please see the Annual Governance Statement on page 31 for information about the committees of the Governing Body including membership and attendance.

The Governing Body 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 the Accountable Officer of Oxfordshire CCG.

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

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year 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 Oxfordshire CCG auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Steve McManus
Accountable Officer
28 June 2023

Annual Governance Statement

Introduction and context

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

As at 30 June 2022, the clinical commissioning group was 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 was responsible for ensuring that the clinical commissioning group was administered prudently and economically and that resources were applied efficiently and effectively, safeguarding financial propriety and regularity. I also had 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 was to ensure that the group had made appropriate arrangements for ensuring that it exercised its functions effectively, efficiently and economically and complied with such generally accepted principles of good governance as are relevant to it.

The CCG's 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 Constitution details the functions, general duties and the powers and authority of the practice members. The matters reserved to the Membership Body (Practice Members) were clearly defined in the Constitution.

The Practice members were represented on the Governing Body through the Area Network and Portfolio Clinical Directors.

To align process across the three CCGs, the BOB CCGs' Governing Bodies have held their meetings 'in common'. One meeting was held in public during the period of this report. The meeting was quorate in terms of executive and lay member representation. A table of members attendance is included in Appendix 1. The meeting concentrated on the close-down of the CCG and establishment of the Integrated Care Board.

The CCG has the following statutory committees:

- Audit Committee

- Remuneration Committee
- Primary Care Commissioning Committee

It has also established:

- Finance Committee
- Executive Committee
- Quality Committee

The terms of reference for each of these committees set out the role and purpose and had been ratified by the Governing Body. The minutes are publicly available as part of the Governing Body meeting papers (except for Remuneration Committee). In a full year each of the committees submited an annual report to the Governing Body giving assurance they were carrying out their duties and would also undertake self-assessments of their effectiveness; the reports for 2021/22 were presented to the Governing Body on 9 June 2022. The Governing Body agreed the mechanism of handover from the CCG committees to the ICB.

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 Scheme of Reservation and Delegation (SoRD) and the Prime Financial Policies, provide the procedural framework within which the CCG discharges its business.

Governing Body Committees

All committees outlined provided assurance to its Governing Body through presentation of their minutes. The Committees may also undertake self-assessments of their effectiveness.

Audit Committee

As for Governing Bodies, the BOB CCGs Audit Committees held their meetings in common. The Committee reviewed critically the CCG's financial reporting and internal control principles; ensured that all the CCG's activities were managed in accordance with legislation and regulations governing the NHS; ensured adequate assurance was in place over the management of significant risks; and ensured that appropriate relationships with both internal and external auditors were maintained.

The Accountable (Chief) Officer and other executive directors attend meetings as requested. Representative of internal audit, external audit and local counter fraud service attended each meeting. The Agenda of the Audit Committee was governed by its annual business cycle.

The Audit Committees met three times during the period of this report. Two of the three meetings were to consider the Annual Report and Accounts 2021/2022. 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 reviewed the framework for the Remuneration, Allowances and Terms of Service for employees of the CCG and the people who provide services to the CCG. It made recommendations to ensure effective oversight of the performance of the CCG's Accountable Officer, Director of Finance and other senior posts, and for scrutiny of any redundancy payments. The overall purpose of the Remuneration Committee was to assure the Governing Bodies that the duty to act effectively, efficiently, and economically was met, and that resources for remuneration did not exceed any amount specified. The Remuneration Committees did not meet in the period covered by this report.

Primary Care Commissioning Committee (PCCC)

As for the Governing Bodies, Audit Committees and Remuneration Committees, the PCCCs held their meetings in common. The PCCC was 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 BOB under delegated authority from NHS England.

The Committees met once during the period covered by this report. A table of members attendance is included in Appendix 1.

Executive Committee

The focus of the Committee in this period was on managing safe transition of commissioning functions and alignment where possible. 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 A&E Delivery Board escalates to the Executive as and when required.

The Executive Committee met twice during the period of this report. A table of members attendance is included in Appendix 1.

Finance Committee

As with the Governing Bodies delegated Committees, and to align services across BOB, the Finance Committees held their meetings in common during Q1 2022/23 (April – June). The Finance Committee scrutinised 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 took relevant decisions as required under delegated authority, such as business cases.

The Committee reviewed reports, identified key issues and risks and gave opinion and assurance to Governing Body on the stewardship of CCG financial resources and their going concern status. Additionally, the Governing Body would require that the Finance Committee reviews specific aspects of financial performance where they require additional scrutiny and assurance.

The Finance Committees met once during the period of this report. A table of members attendance is included in Appendix 1.

Quality Committee

Reviewed and assured provider performance, had oversight of the quality and safety of commissioned services considering safety, effectiveness and patient experience; ensured that the patient voice was heard; reviewed reports on Serious Incidents and Never Events; ensured that there were processes in place to safeguard adults and children; considered national quality inspection reports; monitored arrangements relating to equality and diversity; review the corporate risk register; and received chairs reports from various subcommittees for oversight and assurance.

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

The Committee met once during the period of this report. A table of members attendance is included in Appendix 1.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code considered relevant to clinical commissioning groups. For the period covered by this report we complied with the provisions set out in the Code and applied the principles of the Code.

Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the clinical commissioning group reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations.

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

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

Risk management arrangements and effectiveness

The Audit Committees, at their meetings in common, reviewed the approach to developing a single Risk Management Framework and Corporate Risk Register with an update on risk within the CCG; the Quality Committees reviewed and discussed risks relating to quality and performance; the Finance Committees, at their meetings in common, reviewed and discussed financial risks; the single Primary Care Commissioning Committee reviewed and discussed primary care risks and the Governing Body reviewed and discussed the strategic risks.

Capacity to Handle Risk

The Governance Team co-ordinated the production of risk registers, offer advice and training (when required) and worked with designated risk owners and Executive Directors via individual 1:1s or designated Executive/Director meetings. The purpose of the meetings was to identify any new risk areas; ensuring the appropriate manager, quality of recording and scoring of that risk; the review of all current risks obtaining assurance that appropriate actions and mitigations were in place and that all risks were reviewed and managed appropriately. The Governance Leads also maintained the risk cycle ensuring that timely reminders were sent to risk managers for each risk cycle as per Board and sub-committee meetings.

Risk Assessment

All risks were reviewed and managed at programme board level before being taken to the appropriate executive/director for review/sign-off at place, with review and escalation to the appropriate committee and subsequently Governing Body, providing the necessary assurances that risks were being managed effectively and appropriately.

CCG staff were responsible for their risks and for maintaining risk awareness and identifying and reporting risks as appropriate to their line manager. Staff were to ensure that they familiarised themselves with the Risk Management Policy and Framework and undertook risk management training appropriate to their role.

The BOB CCGs had no appetite for fraud/financial risk and zero tolerance for regulatory breaches. The CCG supported well managed risk taking and ensured that the skill, ability, and knowledge was in place to support innovation and maximise opportunities to improve its service.

Other sources of assurance

Internal Control Framework

A system of internal control was the set of processes and procedures in place in the clinical commissioning group to ensure it delivered its policies, aims and objectives. It was 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 allowed 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) required CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England published a template audit framework.

The CCG's internal auditors carried out their annual audit for 2021/22 and this was reported in the Oxfordshire CCG Annual Report & Accounts 2021/22 available here.

Data Quality

The sourcing of data and management of provider data quality is achieved via contracts. The data contract management processes were well established in the three CCGs, and we continued to capitalise on strong relationships between NHS South Central and West Commissioning Support Unit 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 submitted its Data Security and Protection Toolkit for 2021/22 before the deadline of 30 June 2022 and achieved Standard Exceeded.

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

There were processes in place for incident reporting and investigation of serious incidents. In the period covered by this report there were no incidents which required reporting to the Information Commissioner's Office.

Information governance was reported to the Audit Committees in common as a standing agenda item and was reviewed regularly through the individual CCG management meetings.

Business Critical Models

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

Third party assurances

Where the CCG relied on third party providers, it gained assurance through service level agreements 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 were reported to the Audit Committees in common and informed this governance statement and external audit conclusion.

Control Issues

Performance against constitutional targets has been impacted by the COVID-19 pandemic and further details can be found in the Performance Report. Recovery of performance through the course of 2022/23 will be managed by the new Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board.

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

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

The Audit Committee reviewed and monitored the CCG's financial reporting and internal control principles; to ensure the CCG's 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 Committee monitored contract and financial performance, savings plans and overall use of resources; approved business cases and released finance from allocated reserves; and monitored and provided a scrutiny function to ensure the delivery of projects within the CCG's care programme boards.

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

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

The CCG informed its control framework by the work of Internal and External Audit. The CCG's external auditors were 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 was made available to and reviewed by the Audit Committee and Governing Body.

Delegation of functions

The CCG's Scheme of Reservation and Delegation outlined the control mechanisms in place for delegation of functions and could be found in the CCG's Constitution.

The Governing Body received reports from each of its committees detailing the delivery of work, and associated risks, within their specific remit. Additionally, the Governing Body maintained a high-level overview of the organisation's business and identified and assessed risks and issues straddling committees. These risks were owned and overseen at Governing Body level and scrutinised at each meeting to ensure appropriate management and reporting is in place.

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

Counter fraud arrangements

The CCG was committed to reducing the risk from fraud and corruption and discharged its counter fraud responsibilities locally through its appointed Local Counter Fraud Specialist (LCFS) who acted as the "first line of defence" against fraud, bribery, and corruption, working closely with the CCG and the NHS Counter Fraud Authority (CFA). The Chief Finance Officer was the Executive Lead for counter fraud. The CCG had a Counter Fraud and Corruption Policy and Response plan in place. This was last reviewed in January 2022.

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

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

Head of Internal Audit Opinion

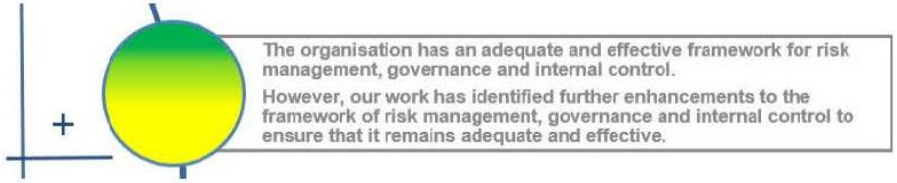
THE ANNUAL INTERNAL AUDIT OPINION

This report provides a three-month internal audit 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 should contribute to the organisation's annual governance reporting.

The opinion

The opinion takes into consideration the framework in place in the period up to and including 30 June 2022; and our cumulative knowledge of Oxfordshire CCG. The opinion does not consider the arrangements of the Integrated Care Board (ICB) or the Integrated Care Partnership (ICP).

For the three months ended 30 June 2022, the head of internal audit opinion for Oxfordshire CCG is as follows:



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

It remains management's responsibility to develop and maintain a sound system of risk management, internal control and governance, and for the prevention and detection of material errors, loss or fraud. The work of internal audit should not be a substitute for management responsibility around the design and effective operation of these systems.

Scope and limitations of our work

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

- internal audit has not reviewed all risks and assurances relating to the organisation;
- the opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework. The assurance framework is one component that the board takes into account in making its annual governance statement (AGS);
- the opinion is based on the findings and conclusions from the work undertaken, the scope of which has been agreed with management / lead individual;
- where strong levels of control have been identified, there are still instances where these may not always be effective. This may be due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance;
- due to the limited scope of our audits, there may be weaknesses in the control system which we are not aware of, or which were not brought to our attention; and

  our opinion is limited to the internal audit work for the three-month period of 1 April 2022 to 30 June 2022; it also takes into consideration our cumulative knowledge of the client.

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

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

The BOB CCGs have been developing a single Risk Management Framework and Corporate Risk Register with an update on risk being undertaken within each CCG. The main focus of the CCG's work in Q1 2022/23 was to ensure there was a safe transition of functions to the Integrated Care Board. A Programme approach was adopted by the three CCGs with senior SROs overseeing each work programme. The due diligence checklist was used to support CCG closedown and a comprehensive report was provided to the last Governing Body meeting as well as being assured by NHS England. I have been informed by the effectiveness of this work in my review and am assured that all functions have been safely transferred to the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board.

Conclusion

No significant internal control issues have been identified.

Steve McManus
Accountable Officer
28 June 2023

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 32.

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 the 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) 1 April to 30 June 2022

Name	Title	Berkshire West CCG Salary (Bands of £5,000) £000	Expense payments (taxable) (Rounded to the nearest £100)* £	Performance Pay and bonuses (Bands of £5,000) £000	Long Term performance pay and bonuses (Bands of £5,000) £000	All Pension related benefits (bands of £2,500) £000	Total (Bands of £5,000) £000
Dr James Kent (**)	ICS Lead & Accountable Officer for BOB CCGs	15-20	0	0-5	0-5	90-92.5	110-115
Ed Capo-Bianco	Urgent & Emergency Care Portfolio Clinical Director	15-20	0	0-5	0-5	17.5-20	35-40
David Chapman	Clinical Chair	15-20	0	0-5	0-5	0-2.5	15-20
Joanne Cogswell (***)	Director of Transformation	25-30	3	0-5	0-5	57.5-60	80-85
Heidi Devenish	Practice Manager Representative	0-5	0	0-5	0-5	20-22.5	20-25
Diane Hedges	Chief Operating Officer and Deputy Chief Executive	30-35	0	0-5	0-5	12.5-15	40-45
Gareth Kenworthy	Director of Finance	30-35	0	0-5	0-5	25-27.5	55-60
Catherine Mountford	Director of Governance	25-30	0	0-5	0-5	65-67.5	90-95
Guy Rooney	Medical Specialist Advisor	0-5	0	0-5	0-5	0-2.5	0-5
Sam Hart (***)	North Network Clinical Director	10-15	10	0-5	0-5	20-22.5	30-35
Andy Valentine	Oxford City Network Clinical Director	15-20	0	0-5	0-5	22.5-25	40-45
Meenu Paul (****)	Clinical Lead, Mental Health/Learning Disabilities	15-20	0	0-5	0-5	37.5-40	50-55
Duncan Smith	Independent Lay Member, Lead for Finance	0-5	0	0-5	0-5	0-2.5	0-5
Wendy Bower (*****)	Lay Member Patient & Public Engagement	0	0	0-5	0-5	0-2.5	0-5
Robert Parkes (*****)	Lay Member Governance	0	0	0-5	0-5	0-2.5	0-5

Notes:

- Taxable expenses and benefits in kind are expressed to the nearest £100.
- **Dr 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 2022/23 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 OCCG. Dr James Kent was contractually entitled to a performance bonus for 2021/22. Total Bonus due in 2021/22 was in the band of £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 leased cars from the CCG workplace lease car scheme. The taxable benefit is shown in the relevant column in the table.
- ****The remuneration for Meenu Paul covers posts other than her senior officer role. Her remuneration for the non-management posts was in the range of £10-15k.
- *****Robert Parkes and Wendy Bower are non-executive directors for Buckinghamshire CCG and Berkshire West CCG respectively. 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 respective CCGs and there is therefore no cost to disclose in the remuneration table above.

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	100-105	6	0-5	0-5	25-27.5	130-135
Heidi Devenish	Practice Manager Representative	0-5	0	0-5	0-5	20-22.5	40-45
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	40-45	36	0-5	0-5	0-2.5	40-45
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	0-2.5	45-50
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 of £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.
- 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 is 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 of £35-40k.
- Robert Parkes and Wendy Bower are non-executive directors for Buckinghamshire CCG and Berkshire West CCG respectively. 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 respective CCGs and there is therefore no cost to disclose in the remuneration table above..

Pension Benefits as at 30 June 2022

Name	Title	Real increase in pension at age 60 (bands of £2,500) £'000	Real increase in pension lump sum at age 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 30 June 2022 (bands of £5,000) £'000	Lump sum at age 60 related to accrued pension at 30 June 2022 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1st April 2022 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 30 June 2022 £'000	Employer's contribution to stakeholder pension £'000
Dr James Kent (*)	ICS Lead & Accountable Officer for BOB CCGs	2.5-5	0-2.5	10-15	0-5	125	67	203	0
Ed Capo-Bianco	Urgent & Emergency Care Portfolio Clinical Director	0-2.5	0-2.5	10-15	15-20	155	11	173	0
Joanne Cogswell	Director of Transformation	2.5-5	0-2.5	15-20	0-5	139	37	184	0
Heidi Devenish	Practice Manager Representative	0-2.5	0-2.5	5-10	0-5	75	15	92	0
Diane Hedges	Chief Operating Officer and Deputy Chief Executive	0-2.5	0-2.5	40-45	70-75	805	0	587	0
Gareth Kenworthy	Director of Finance	0-2.5	0-2.5	45-50	75-80	715	26	768	0
Catherine Mountford	Director of Governance	2.5-5	2.5-5	50-55	135-140	1,108	0	94	0
Sam Hart	North Network Clinical Director	0-2.5	0-2.5	10-15	0-5	138	12	156	0
Andy Valentine	Oxford City Network Clinical Director	0-2.5	0-2.5	15-20	20-25	209	14	232	0
Meenu Paul	Clinical Lead, Mental Health/Learning Disabilities	0-2.5	0-2.5	15-20	20-25	229	27	265	0

Notes: CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023-24 CETV figures.

- Full year pension values are shown although the reporting period is April to June 2022.
- *Dr James Kent is joint Chief Officer for Buckinghamshire CCG, Oxfordshire CCG and Berkshire West CCG. Salary disclosure is for Oxfordshire CCG share of costs (40.15%).
- Lay members and the Specialist Medical 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 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	15	155	0
Kiren Collison	Clinical Chair to 18.7.2021		0-2.5	0-2.5	15-20	25-30	248	6	269	0
Joanne Cogswell	Director of Transformation		0-2.5	0-2.5	10-15	0	111	27	139	0
Heidi Devenish	Practice Manager Representative		0-2.5	0-2.5	5-10	0	52	23	75	0
Diane Hedges	Chief Operating Officer and Deputy Chief Executive		0-2.5	0-2.5	40-45	65-70	747	54	805	0
Gareth Kenworthy	Director of Finance		0-2.5	0-2.5	40-45	75-80	664	48	715	0
James Kent	Accountable Officer		2.5-5	0-2.5	5-10	0-5	67	36	125	0
Catherine Mountford	Director of Governance		0-2.5	2.5-5	45-50	125-130	1,042	61	1,108	0
Sam Hart	North Network Clinical Director		0-2.5	0-2.5	10-15	0	149	0	138	0
Andy Valentine	Oxford City Network Clinical Director		0-2.5	0-2.5	15-20	20-25	188	21	209	0
Meenu Paul	Clinical Lead		0-2.5	0-2.5	5-10	20-25	137	2	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).

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 benefits and corresponding CETV do not allow for any potential adjustment in relation to the McCloud judgement.

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).

Multiple Pay

Pay Ratio Information

As at 30 June 2022, remuneration ranged from £16k to £200k (2021/22: £23k-£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.

2022-23	25th percentile	Median	75th percentile
Total remuneration (£)	46,239	55,164	100,544
Salary component of total remuneration (£)	46,239	55,164	100,544
Pay ratio information	3.41	2.86	1.57
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

Year on Year Pay ratio variance %	**-9%**	**-1%**	**-18%**

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

The banded remuneration of the highest paid director/member of the CCG Governing Body in the financial year 2022/23 was £155k-£160k (2021/22 was £150k to £155k) on an annualised basis. The relationship to the remuneration of the organisation's workforce is disclosed in the table below in fair pay disclosure.

In 2022-23, 6 employees (2021-22 no employee) received remuneration in excess of the highest-paid director/member of the CCG Governing Body. 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 2.86 times the median salary compared to 2.87 last year. The 25th percentile ratio has also reduced slightly i.e. 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.

Fair Pay Disclosures

The financial year 2022/23 figures from the Workforce Remuneration section have 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	22/23	21/22	Change	% Change	% Change 21/22
Highest paid director					
Salary and Allowances	157,500.00	152,500.00	5,000.00	3.28%	0.00%
Performances and bonuses	0	0	0	0.00%	0.00%
Employees of the entity taken as a whole (Average)					
Salary and Allowances	74,681.37	67,337.22	7,344.15	10.91%	0.68%
Performances and bonuses	0.00	18,200.00	-18,200.00	0.00%	0.00%

There has been a change in the salary of the highest paid director year on year by 3.28% (2021/22 was 0.00%) and overall employees' salaries have increased by 10.91% on average as a result of pay award for 2022/23 was 4-5.5% (2021/22 was 0.68%).

Bonuses paid have been included in the calculation. No employee received a bonus in 2022/23 and one employee in 2021/22 and no other bonuses were received by the remaining workforce.

Staff Report

Staff sickness absence

Below outlines OCCG's sickness absence data from 1 April 2022 – 30 June 2022

	1 April 2022 – 30 June 2022
Sum of full time equivalent (FTE)	192
Sum of FTE days available	10,031
Average annual sick days per FTE	4.3

Sickness absence is managed in a supportive and effective manner by OCCG managers, with professional advice and targeted support from human resources (HR), occupational health, 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 which organise events throughout the year with a large number of staff participating.

Staff numbers and gender analysis

OCCG had a workforce comprised of employees from a wide variety of professional groups. At the end of June 2022 OCCG employed 130 staff (headcount), of which 88 were women and 43 men. At the end of June 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	3	9	11
Very Senior Managers	3	0	3
All other Employees	82	39	121
Total Employees	88	48	132

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 of 30 June 2022.

	Permanently employed Number	Other Numbers	22/21 Total Number
Total (headcount)	132	24	155

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 between 1 April 2022 to June 2023.

	Permanently employed Number	Other Numbers	Total Number
Average number of whole-time equivalent people	81.22	24.09	105.31
Of which: (WTE) people engaged on capital projects	0	0	0

Staff turnover from 1 April to 30 June 2022 for OCCG was 6.07%.

Employee benefits and cost

Below are the employee benefits and costs as at 30 June 2022:

	Permanent Employees £'000	Total Other £'000	2022-23 Total £'000
Employee Benefits			
Salaries and wages	1,388	645	**2,033**
Social security costs	168	-	**168**
Employer Contributions to NHS Pension scheme	252	-	**252**
Apprenticeship Levy	3	-	**3**
Termination benefits	77	-	**77**
Gross employee benefits expenditure	**1,888**	**645**	**2,533**

Below are the employee benefits and costs for 2021/22:

	Permanent Employees £'000	Total Other £'000	2021-22 Total £'000
Employee Benefits			
Salaries and wages	5,384	956	**6,340**
Social security costs	539	-	**539**
Employer Contributions to NHS Pension scheme	858	-	**858**
Apprenticeship Levy	10	-	**10**
Gross employee benefits expenditure	**6,792**	**956**	**7,748**

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

Trade union official facility time

OCCG had one trade union, but no trade union facilities time has been recorded for the period 1 April to 30 June 2022.

Expenditure on consultancy

Expenditure on consultancy between 1 April to 30 June 2022 was £409k (£1,670k in 2021/22) as per Note 5 in the financial accounts on page 79. 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
- Liaison Financial Services LTD – review of 1:1 care costs at care homes to ensure provision of care was appropriate and cost effective
- IRG Advisors LLP – recruitment services for sourcing executive team candidates
- Andrew Thomas & Co LTD – additional support for the Finance Function
- Freshwater Ltd – additional Communications capacity

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 of 30 June 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, including special (non-contractual) payments

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000								
£10,000 - £25,000								
£25,001 - £50,000	1	£46,666.67	1	£30,321.25				
£50,001 - £100,000								
£100,001 - £150,000								
£150,001 –£200,000								
>£200,000								
TOTALS	1	£46,666.67	1	£30,321.25				

Analysis of Other Agreed Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	n/a	n/a
Mutually agreed resignations (MARS) contractual costs	n/a	n/a
Early retirements in the efficiency of the service contractual costs	n/a	n/a
Contractual payments in lieu of notice*	1	30
Exit payments following Employment Tribunals or court orders	n/a	n/a
Non-contractual payments requiring HMT approval**	n/a	n/a
TOTAL		30

Redundancy and other departure cost have been paid in accordance with the provisions of NHS OCCG Compulsory Redundancy Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table. Other agreed departures of £30k is agreed contractual payment in lieu of notice (PILON).

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 had 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 continued until the end of the CCG.
- Weekly Friday Wellbeing was 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.

The activities have been based on MS Teams and have 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.

Staff Policies

OCCG recognise and value the importance of maintaining positive working relationships with its staff and their representatives. Since December 2020 we had 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 the 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 the trade unions outlined in the national NHS Terms and Conditions of Service Handbook that have members employed within the organisation.

The CCG had a Health and Wellbeing Policy and an active, staff-led, Health and Wellbeing Group which supports implementation of this policy which had 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 employees' wellbeing. The Wellbeing Wednesday sessions commenced in 2020 are available to staff across the three CCGs.

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

- 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 action plans developed by staff to address different aspects of the feedback.

Disability information

OCCG had 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 that do not discriminate against 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 on 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 workplace and safe working environment is critical to our continued success and accordingly, we view our responsibilities for health, safety and welfare with the utmost importance. However, in the past year, the majority of staff have been working from home. During this time, considerable effort had 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 monitors) to accommodate individual staff needs. Health and Safety training forms part of the suite of statutory and mandatory training which is undertaken by all employees.

Whistleblowing

Oxfordshire CCG had a whistleblowing policy that was communicated to all staff and was 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 senior managers and related narrative notes on page 40 and 41, pension benefits of senior managers and related narrative on pages 42 and 43, the fair pay disclosures and related narrative notes on page 45 to 47 and exit packages and any other agreed departures on page 52 and 53.

Steve McManus,
Accountable Officer
28 June 2023

Parliamentary Accountability and Audit Report

Oxfordshire CCG is not required to produce an Accountability and Audit but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report. For 1 April to 30 June 2022 there were no remote contingent liabilities, losses and special payments, gifts, fees or charges.

Steve McManus
Accountable Officer
28 June 2023

Appendix 1: Table of Attendance for Board and Committee Meetings

Oxfordshire CCG – Governing Body Meetings 1 April – 30 June 2022

Attendees	09 June 2022
All Voting Members	
Wendy Bower	Y
Dr Ed Capo-Bianco	Y
Dr David Chapman	Y
Dr Sam Hart	A
Dr James Kent	Y
Gareth Kenworthy	Y
Robert Parkes	Y
Dr Meenu Paul	Y
Dr Guy Rooney	Y
Debbie Simmons	Y
Duncan Smith	Y
Dr Andy Valentine	Y
Non-voting Members	
Ansaf Azhar	A
Stephen Chandler	A
Jo Cogswell	Y
Heidi Devenish	Y
Diane Hedges	A
Catherine Mountford	Y

Oxfordshire CCG – Audit Committee Meetings 1 April – 30 June 2022

Attendees	22 April 2022	27 April 2022	15 June 2022
Wendy Bower	Y	Y	A
Robert Parkes	Y	Y	Y
Duncan Smith	Y	Y	Y

Oxfordshire CCG – Executive Committee Meetings 1 April – 30 June 2022

Attendees	April 2022	May 2022
Ed Capo-Bianco	Y	Y
David Chapman	Y	Y
Jo Cogswell	Y	Y
Sam Hart	Y	N
Diane Hedges	Y	N
Dr James Kent	Y	N
Gareth Kenworthy	Y	Y
Catherine Mountford	N	Y
Dr Meenu Paul	N	Y

Debbie Simmons	N/A	Y
Andy Valentine	Y	Y

Oxfordshire CCG – Finance Committee Meetings 1 April – 30 June 2022

Attendees	09 June 2022
Dr Ed Capo-Bianco	Y
Diane Hedges	A
James Kent	A
Gareth Kenworthy	Y
Robert Parkes	Y
Jenny Simpson	Y
Duncan Smith	Y

Oxfordshire CCG – Primary Care Commissioning Committee Meetings 1 April – 30 June 2022

Attendees	16 June 2022
Voting Members	
Dr Raj Bajwa	Y
Wendy Bower	A
David Chapman	Y
Jo Cogswell	Y
Tony Dixon	Y
Kate Holmes	Y
Dr Abid Irfan	Y
Dr James Kent	A
Rebecca Mallard-Smith	Y
Dr Kajal Patel	Y
Dr Meenu Paul	Y
Rashmi Sawhney	Y
Debbie Simmons	Y
Duncan Smith	Y
Non-voting members	
Sushma Acquilla	A
Neil Bolton-Heaton	A
Julia Booth	A
Adrian Chamberlain	Y
Julie Dandridge	Y
Professor Tracy Daszkiewicz	A
Sanjay Desai	Y
Colin Hobbs	Y
Stuart Ireland	Y
Mandeep Kaur Bains	A
Dr Jim Kennedy	A
Rebecca Mallard-Smith	Y
Zoe McIntosh	Y
James McNally	Y
Rosalind Pearce	Y

Andrew Sharp	Y
Catherine Williams	A

Oxfordshire CCG – Remuneration Committee 1 April – 30 June 2022
No Remuneration Committee meetings were held during this period

Oxfordshire CCG – Quality Committee Meetings 1 April – 30 June 2022

Name	April 22	Jun 22
Voting members		
Dr Guy Rooney	Y	Y
Helen Ward	Y	Y
Debbie Simmons	N	Y
Diane Hedges	Y	N
Shakiba Habibula or nominated deputy	Y	Y
Pippa Corner or nominated deputy	Y	Y
Marie Crofts or nominated deputy	Y	Y
Rob Bale or nominated deputy	Y	Y
Dr Karl Marlowe	N	N
Dr Kathryn Brown or nominated deputy	Y	Y
Prof Helen Young or nominated deputy	Y	Y
Dr Andy Valentine	Y	N
Dr Meenu Paul	Y	Y
Sam Foster or nominated deputy	Y	Y
Non-voting members		
Hillary Seal	Y	Y
Rosalind Pearce or nominated deputy	Y	Y

FINANCIAL ACCOUNTS

FOR THE PERIOD ENDED 30 JUNE 2022

NHS OXFORDSHIRE Clinical Commissioning Group

Financial Information - Accounts Year Ended 30 June 2022

These accounts for the year ended 30th June 2022 have been prepared by Oxfordshire Clinical Commissioning Group under a Direction issued by the NHS Commissioning Board, now known as NHS England under the National Health Service Act 2006.

NHS Oxfordshire Clinical Commissioning Group - Annual Accounts 2022-23 as at 30 June 2022

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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS BUCKINGHAMSHIRE, OXFORDSHIRE AND BERSKHIRE WEST INTEGRATED CARE BOARD

Opinion

We have audited the financial statements of NHS Oxfordshire Clinical Commissioning Group ("the CCG") for the three-month period ended 30 June 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 19, 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 2022/23 HM Treasury's Financial Reporting Manual (the 2022/23 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2022 to 2023 and the Accounts Direction issued by NHS England with the approval of the Secretary of State.

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Oxfordshire CCG as at 30 June 2022 and of its net expenditure for the three-month period then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022 to 2023; and
- have been properly prepared in accordance with the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

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 18 Events After the Reporting Period, which describes the Clinical Commissioning Group's transition into the NHS 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 other matters prescribed by the Code of Audit Practice

In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and
- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022 to 2023.

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 2022 to 2023; 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 three-month period ended 30 June 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 page 28 to 29, 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.

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 National Health Service Act 2006, the Health and Social Care Act 2012, the Health and Care Act 2022 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 year-end accounts were free form material mis-statement and performed substantive procedures on Department of Health 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, 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. NHS Oxfordshire CCG has robust policies and procedures to mitigate the 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 risks 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 January 2023 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 three-month period ended 30 June 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. The Code of Audit Practice does not require us to refer to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resource 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

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

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.

Maria Grindley (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Reading
30 June 2023

Statement of Comprehensive Net Expenditure for the year ended 30 June 2022

	Note	2022-23 £'000	2021-22 £'000
Income from sale of goods and services	2	(2,471)	(3,393)
Other operating income	2	(13)	(596)
Total operating income		**(2,484)**	**(3,989)**
Staff costs	4	2,533	7,748
Purchase of goods and services	5	309,463	1,274,896
Depreciation and impairment charges	5	19	131
Provision expense	5	-	(23)
Other Operating Expenditure	5	141	564
Total operating expenditure		**312,156**	**1,283,316**
Net Operating Expenditure		**309,672**	**1,279,327**
Total Net Expenditure for the Financial Year		**309,672**	**1,279,327**
Comprehensive Expenditure for the year		**309,672**	**1,279,327**

The notes on pages 70 to 89 form part of this statement

Statement of Financial Position as at 30 June 2022

	Note	2022-23 £'000	2021-22 £'000
Non-current assets:			
Property, plant and equipment	7	42	58
Intangible assets	8	30	32
Total non-current assets		72	90
Current assets:			
Trade and other receivables	9	11,116	14,793
Cash and cash equivalents	10	2,822	177
Total current assets		**13,939**	14,971
Total current assets		**13,939**	14,971
Total assets		**14,011**	15,062
Current liabilities			
Trade and other payables	11	(66,807)	(80,863)
Provisions		(1,232)	(1,232)
Total current liabilities		**(68,039)**	(82,095)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(54,028)**	(67,033)
Assets less Liabilities		**(54,028)**	(67,033)
Financed by Taxpayers' Equity			
General fund		(54,028)	(67,034)
Total taxpayers' equity:		**(54,028)**	(67,034)

The notes on pages 70 to 89 form part of this statement

The financial statements on pages 70 to 89 were approved by the Audit Committee on behalf of the Governing Body on 29 June 2023 and signed on its behalf by:

Steve McManus
Chief Accountable Officer

Matthew Metcalf
Chief Finance Officer

Statement of Changes In Taxpayers Equity for the year ended 30 June 2022

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2022-23		
Balance at 01 April 2022	(67,034)	**(67,034)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2022-23		
Net operating expenditure for the financial year	(309,672)	**(309,672)**
Net funding	322,677	**322,677**
Balance at 30 June 2022	**(54,029)**	**(54,029)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22		
Balance at 01 April 2021	(64,382)	**(64,382)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22		
Net operating costs for the financial year	(1,279,327)	(1,279,327)
Net funding	1,276,676	1,276,676
Balance at 31 March 2022	**(67,033)**	**(67,033)**

The notes on pages 70 to 89 form part of this statement

Statement of Cash Flows for the year ended 30 June 2022

	Note	2022-23 £'000	2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(309,672)	(1,279,327)
Depreciation and amortisation		19	131
(Increase)/decrease in trade & other receivables		3,677	(8,240)
Increase/(decrease) in trade & other payables		(14,055)	12,099
Provisions utilised		0	(76)
Increase/(decrease) in provisions		0	(23)
Net Cash Inflow (Outflow) from Operating Activities		**(320,031)**	(1,275,437)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		0	(13)
Net Cash Inflow (Outflow) from Investing Activities		**0**	(13)
Net Cash Inflow (Outflow) before Financing		**(320,031)**	(1,275,449)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		322,677	1,276,676
Net Cash Inflow (Outflow) from Financing Activities		**322,677**	1,276,676
Net Increase (Decrease) in Cash & Cash Equivalents		**2,646**	1,226
Cash & Cash Equivalents at the Beginning of the Financial Year		**177**	(1,049)
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**2,823**	177

The notes on pages 70 to 89 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 2022-23 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 Cmmissioning 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.

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021. The Bill allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Cmmissioning Groups (CCG). ICBs took on the commissioning functions of CCGs. The CCG functions, assets and liabilities were transferred to an ICB on 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.

1.5 **Pooled Budgets**

The Clinical Commissioning Group has entered into a pooled budget arrangement with Oxfordshire County Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for 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 and Note 17 provides details of the income and expenditure.

The pool is 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.

1.6 **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

1.7 **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.

1.8 **Employee Benefits**

1.8.1 **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.

1.8.2 **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.

1.9 **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.

1.10 **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.

1.11 **Property, Plant & Equipment**

1.11.1 **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.

1.11.2 **Property, Plant & Equipment cont'd**

1.11.3 **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.

Notes to the financial statements

1.11.4 **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.

1.12 **Intangible Assets**

1.12.1 **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.

1.12.2 **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.

1.12.3 **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.

1.13 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.
The clinical commissioning group assesses whether a contract is or contains a lease, at inception of the contract.

Notes to the financial statements

1.13.1 **The Clinical Commissioning Group as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16.

Lease payments included in the measurement of the lease liability comprise i.e.
-Fixed payments,
-variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement,
-the amount expected to be payable under residual value guarantees,
-the exercise price of purchase options, if it is reasonably certain the option will be exercised and
-payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.14 **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.

1.15 **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 3.27% (2021-22: 0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 3.20% (2021-22: 0.70%) 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 3.51% (2021-22 0.95%) 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 3.00% (2021-22: 0.66%) 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.

Notes to the financial statements

1.16 **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.

1.17 **Non-clinical Risk Pooling**

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

1.18 **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.

1.19 **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.

1.19.1 **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.

1.20 **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.

1.21 **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.

1.22 **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

1.23 **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. These are regularly reviewed.

1.23.1 **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).

1.23.2 **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 30 June 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 and contractual 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.

1.24 **Adoption of new standards**

On 1 April 2022, the Clinical Commissioning Group adopted IFRS 16 ‘Leases’. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases.

Under IFRS 16 the group will recognise a right-of-use asset representing the group’s right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.

In addition, the group will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

Impact assessment

The Clinical Commissioning Group has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.

IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and therefore the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.

The group has utilised three further practical expedients under the transition approach adopted:
a) The election to not make an adjustment for leases for which the underlying asset is of low value.
b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.
c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.

As of 1 April 2022, the group recognised £0m or right-of-use assets and lease liabilities of £0m. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was an £0m impact to tax payers’ equity. The Clinical commissioning Group have no lease recognition as of 1 April 2022 as a result of short term lease in the reporting period.

The group has assessed that there is no significant impact on its current finance leases due to the immaterial value on the statement of financial position and no significant impact on the limited transactions it undertakes as a lessor because IFRS 16 has not substantially changed the accounting arrangements for lessors.

The following table reconciles the group’s operating lease obligations at 31 March 2022, disclosed in the group’s 21/22 financial statements, to the lease liabilities recognised on initial application of IFRS 16 at 1 April 2022.

1.25 **New and revised IFRS Standards in issue but not yet effective**

● 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

	2022-23 Total	2021-22 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**2,028**	2,742
Prescription fees and charges	**199**	590
Other Contract income	**244**	61
Total Income from sale of goods and services	**2,471**	**3,393**
Other operating income		
Other non contract revenue	**13**	596
Total Other operating income	**13**	**596**
Total Operating Income	**2,484**	**3,989**

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	**1,945**	0
Non NHS	**83**	199
Total	**2,028**	**199**
Timing of Revenue		
Point in time	**2,028**	199
Total	**2,028**	**199**

4. Employee benefits and staff numbers

4.1.1 Employee benefits	**Permanent Employees £'000**	**Other £'000**	**Total 2022-23 Total £'000**
Employee Benefits			
Salaries and wages	1,388	645	**2,033**
Social security costs	168	-	**168**
Employer Contributions to NHS Pension scheme	252	-	**252**
Apprenticeship Levy	3	-	**3**
Termination benefits	77	-	**77**
Gross employee benefits expenditure	**1,888**	**645**	**2,533**

4.1.1 Employee benefits	Permanent Employees £'000	Other £'000	Total 2021-22 Total £'000
Employee Benefits			
Salaries and wages	5,384	956	**6,340**
Social security costs	539	-	**539**
Employer Contributions to NHS Pension scheme	858	-	**858**
Apprenticeship Levy	10	-	**10**
Gross employee benefits expenditure	**6,792**	**956**	**7,748**

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 Average number of people employed	**2022-23**			2021-22		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**81.22**	**24.09**	**105.31**	77.28	23.72	101.00

4.3 Exit packages agreed in the financial year	**2022-23 Compulsory redundancies**		**2022-23 Other agreed departures**		**2022-23 Total**	
	Number	£	Number	£	Number	£
£25,001 to £50,000	1	46,667	1	30,321	1	76,988
Total	**1**	**46,667**	**1**	**30,321**	**1**	**76,988**

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

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Redundancy Scheme.

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

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.4 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:

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

4.4.2 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 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.

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

	2022-23 Total £'000	2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	179	497
Services from foundation trusts	206,537	857,648
Services from other NHS trusts	1,454	3,721
Purchase of healthcare from non-NHS bodies	36,273	153,807
Prescribing costs	22,316	95,787
GPMS/APMS and PCTMS	31,127	123,918
Supplies and services – clinical	713	2,847
Supplies and services – general	9,690	32,193
Consultancy services	409	1,670
Establishment	271	2,315
Transport	0	1
Premises	261	2
Audit fees	135	138
Other professional fees	70	164
Legal fees	5	113
Education, training and conferences	25	76
Total Purchase of goods and services	**309,465**	**1,274,896**
Depreciation and impairment charges		
Depreciation	17	123
Amortisation	2	8
Total Depreciation and impairment charges	**19**	**131**
Provision expense		
Provisions	-	(23)
Total Provision expense	**-**	**(23)**
Other Operating Expenditure		
Chair and Non Executive Members	30	118
Grants to Other bodies	6	25
Research and development (excluding staff costs)	105	421
Total Other Operating Expenditure	**141**	**564**
Total operating expenditure	**309,625**	**1,275,568**

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 £6.3m were received in the first quarter of 2022-23 (£121.6m in 2021-22) on behalf of the ICS, there were no transfer across the 3 CCGs (£82.5m in 2021-22) leaving hosted ICS allocations of £6.3m within the CCG (£38.2m in 2021-22). Corresponding expenditure is mainly shown in Table 5 under Supplies and services – general and Services from other CCGs.

The base External Audit fee for Quarter 1 2022-23 is £115k excluding VAT (2021-22 £70k).

6.1 Better Payment Practice Code

Measure of compliance	**2022-23 Number**	**2022-23 £'000**	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	2,385	77,874	8,573	241,032
Total Non-NHS Trade Invoices paid within target	2,276	74,782	8,188	235,836
Percentage of Non-NHS Trade invoices paid within target	**95.4%**	**96.0%**	**95.5%**	**97.8%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	152	212,682	907	909,363
Total NHS Trade Invoices Paid within target	133	212,066	874	908,201
Percentage of NHS Trade Invoices paid within target	**87.5%**	**99.7%**	**96.4%**	**99.9%**

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 Property, plant and equipment

2022-23	**Information technology £'000**	**Furniture & fittings £'000**	**Total £'000**
Cost or valuation at 01 April 2022	821	873	1,695
Disposals other than by sale	(455)	(300)	(755)
Cost/Valuation at 30 June 2022	**366**	**573**	**939**
Depreciation 01 April 2022	763	873	1,637
Disposals other than by sale	(455)	(300)	(755)
Charged during the year	17	0	17
Depreciation at 30 June 2022	**325**	**573**	**898**
Net Book Value at 30 June 2022	**42**	**(0)**	**42**
Purchased	42	(0)	42
Total at 30 June 2022	**42**	**(0)**	**42**
Asset financing:			
Owned	42	(0)	42
	42	(0)	42
Total at 30 June 2022			

7.1 Economic lives

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

8. Intangible non-current assets

2022-23	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2022	40	**40**
Cost / Valuation At 30 June 2022	**40**	**40**
Amortisation 01 April 2022	8	**8**
Charged during the year	2	**2**
Amortisation At 30 June 2022	**10**	**10**
Net Book Value at 30 June 2022	**30**	**30**
Purchased	30	**30**
Total at 30 June 2022	**30**	**30**

8.1 Economic lives

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

9. Trade and other receivables	**Current 2022-23 £'000**	Current 2021-22 £'000
NHS receivables: Revenue	160	8
NHS prepayments	-	-
NHS accrued income	4,246	660
NHS Contract Receivable not yet invoiced/non-invoice	-	-
NHS Non Contract trade receivable (i.e pass through funding)	24	980
Non-NHS and Other WGA receivables: Revenue	205	1,911
Non-NHS and Other WGA prepayments	851	1,523
Non-NHS and Other WGA accrued income	816	805
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	845	1,593
Expected credit loss allowance-receivables	(3)	(3)
VAT	100	245
Other receivables and accruals	3,870	7,070
Total Trade & other receivables	**11,114**	**14,793**
Total current and non current	**11,114**	**14,793**

9.1 Receivables past their due date but not impaired

	2022-23 DHSC Group Bodies £'000	2022-23 Non DHSC Group Bodies £'000	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	5	27	3	1,879
By three to six months	0	731	26	6
By more than six months	27	7	4	0
Total	**32**	**765**	**33**	**1,886**

9.2 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)**
Total	**(3)**	**-**	**(3)**

10. Cash and cash equivalents

	2022-23	2021-22
	£'000	£'000
Balance at 01 April 2022	177	(1,049)
Net change in year	2,645	1,226
Balance at 30 June 2022	**2,822**	**177**
Made up of:		
Cash with the Government Banking Service	2,822	177
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**2,822**	**177**
Balance at 30 June 2022	**2,822**	**177**

There was no overdraft in the first quarter of 2022-23.

The Clinical Commissioning Group does not hold any patients' money neither held money on behalf of NHS Clinical Commissioning Group by the 30 June 2022.

11. Trade and other payables

	Current	Current
	2022-23	2021-22
	£'000	£'000
NHS payables: Revenue	5,118	2,706
NHS accruals	4,303	3,572
Non-NHS and Other WGA payables: Revenue	7,861	15,261
Non-NHS and Other WGA accruals	19,959	25,288
Non-NHS and Other WGA deferred income	79	80
Social security costs	102	75
Tax	90	56
Other payables and accruals	29,296	33,824
Total Trade & Other Payables	**66,808**	**80,863**
Total current and non-current	**66,808**	**80,863**

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 30 June 2022.

12. Provisions

	Current 2022-23 £'000	Current 2021-22 £'000
Continuing care	1,232	1,232
Other	-	-
Total	**1,232**	**1,232**
Total current and non-current	**1,232**	**1,232**

	Continuing Care £'000	**Total £'000**
Balance at 01 April 2022	**1,232**	**1,232**
Balance at 30 June 2022	**1,232**	**1,232**
Expected timing of cash flows:		
Within one year	1,232	**1,232**
Balance at 30 June 2022	**1,232**	**1,232**

Pension payments are made quarterly and amounts are known. The pension provision is based on life expectancy.

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 30 June 2022 (31 March 2022 £Nil).

There was one provision of £30k included by the NHS Litigation Authority as at 30 June 2022 in respect of clinical negligence liabilities of the Clinical Commissioning Group (£30k at 31st March 2022).

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

13. Contingencies

	2022-23 £'000
Contingent liabilities	
Other	30
Net value of contingent liabilities	30

14. Financial instruments

14.1 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.

14.1.1 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.

14.1.2 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.

14.1.3 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.

14.1.4 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.

14.1.5 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.

14. Financial instruments cont'd

14.2 Financial assets

	Financial Assets measured at amortised cost	
		Total
	2022-23	2021-22
	£'000	£'000
Trade and other receivables with NHSE bodies	2,839	641
Trade and other receivables with other DHSC group bodies	1,926	1,597
Trade and other receivables with external bodies	6,000	10,789
Cash and cash equivalents	2,822	177
Total at 30 June 2022	**13,587**	**13,204**

14.3 Financial liabilities

	Financial Liabilities measured at amortised cost	
		Total
	2022-23	2021-22
	£'000	£'000
Trade and other payables with NHSE bodies	1,895	**1,143**
Trade and other payables with other DHSC group bodies	8,808	**6,296**
Trade and other payables with external bodies	56,431	**73,212**
Total at 30 June 2022	**67,134**	**80,651**

15. Operating segments

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

16. 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:

16.1 Interests in joint operations

			Amounts recognised in Entities books ONLY 2022-23				Amounts recognised in Entities books ONLY 2021-22			
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Assets**	**Liabilities**	**Income**	**Expenditure**	**Assets**	**Liabilities**	**Income**	**Expenditure**
			£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Better Care Fund (BCF) Pool	Oxfordshire CCG (OCCG) and Oxfordshire County Council (OCC)	The BCF pool provides health and social care services to adults of working age and older adults. Services include those covering care homes provision as well as services designed to promote hospital avoidance and prevention of admission to hospital.	3,055	(3,055)	(27,181)	27,181	7,375	(7,375)	(108,158)	108,158
Adults with Care and Social Needs (ACSN)	Oxfordshire CCG (OCCG) and Oxfordshire County Council (OCC)	The ACSN pool provides health and social care services to children and adults of working age. Services include those covering mental health, acquired brain injury and learning disability.	210	(210)	(21,797)	21,797	1,195	(1,195)	(92,160)	92,160

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 -i.e, 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.

16b. 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 30 June 2022

	Total Contributions £'000
Partner Contributions	
Oxfordshire Clinical Commissioning Group	27,181
Oxfordshire CC Social & Community Services Directorate	29,007
Total Funding	56,188
Total Expenditure	56,188
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.

	30 June 2022 £'000
CURRENT ASSETS	
Debtors - Amounts falling due within 1 year	
Other prepayments and accrued income	3,055
TOTAL CURRENT ASSETS	3,055
Creditors - Amounts falling due within 1 year	
Accruals and deferred income	(913)
NET CURRENT ASSETS / (LIABILITIES)	2,142
Provisions for Liabilities & Charges	(2,142)
TOTAL ASSETS EMPLOYED	0

16 Joint arrangements - interests in joint operations cont'd

16c. 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 30 June 2022

	Total Contributions £'000
Partner Contributions	
Oxfordshire CCG	21,797
Oxfordshire CC Social & Community Services Directorate	27,102
Total Funding	48,899
Total Expenditure	48,899
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.

	30 June 2022 £'000
CURRENT ASSETS	
Debtors - Amounts falling due within 1 year	
Other prepayments and accrued income	210
TOTAL CURRENT ASSETS	210
Creditors - Amounts falling due within 1 year	
Accruals and deferred income	(210)
NET CURRENT ASSETS / (LIABILITIES)	0
Provisions for Liabilities & Charges	
TOTAL ASSETS EMPLOYED	0

17. 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 Quarter 1, 2022-23 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 individuals are as follows:

Related Party	Payments to Related Party (Apr22-Jun22) £'000	Receipts from Related Party (Apr22-Jun22) £'000	Amounts owed to Related Party as 30 Jun 22 £'000	Amounts due from Related Party as 30 Jun 22 £'000
Age UK Oxfordshire	-	9	-	-
Buckinghamshire Healthcare NHS Trust	972	2	-	-
Goring & Woodcote Medical Practice	525	-	-	-
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	1,198	-	-	-
Hollow Way Medical Centre	317	-	-	-
Islip Medical Practice	2	-	-	-
NHS BERKSHIRE WEST CCG	54	15	-	-
NHS BUCKINGHAMSHIRE CCG	230	8	-	-
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	134,820	284	-	-
Oxfordshire County Council	32,624	3,102	1,608	925
PRINCIPAL MEDICAL	3,433	96	-	-
ROYAL BERKSHIRE NHS FOUNDATION TRUST	6,445	-	-	-
SEOX Ltd	53	-	-	-
ST LUKE'S HOSPITAL	-	8	-	-
Summertown Health Centre	463	-	-	-
Woodlands Medical Centre	409	-	-	-

17 Related Party transactions cont'd

Related Party

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 optmisation and Mental Health	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

17. Related party transactions cont'd

Department of Health and Social Care (DHSC) related party information for group bodies 2022-23

The individuals and entities that the Department of Health and Social Care identifies as meeting the definition of Related Parties set out in IAS 24 (Related Party Transactions) are also deemed to be related parties of entities within the Departmental Group.

This note therefore sets out the individuals and entities which we have assessed as meeting the IAS 24 definition of Related Parties for the year ending 31 March 2023 to assist group bodies in preparing disclosures compliant with IAS 24.

Ministers	**Senior Officials**	**Non-executive Directors**
The Rt Hon Steve Barclay MP	Sir Chris Wormald KCB	Kate Lampard
The Rt Hon Dr Thérèse Coffey MP	Professor Sir Christopher Whitty KCB	Doug Gurr
The Rt Hon Sajid Javid MP	Shona Dunn	Gerry Murphy
Edward Argar MP	Clara Swinson CB	Julian Hartley
Gillian Keegan MP	Jonathan Marron	
Dr Caroline Johnson MP	Matthew Style	
Robert Jenrick MP	Michelle Dyson	
William Quince MP	Andrew Brittain	
Helen Whately MP	Stephen Oldfield	
Maggie Throup MP	Matthew Gould	
Maria Caulfield MP	Professor Lucy Chappell	
James Morris MP	Jenny Richardson	
Neil O'Brien MP	Hugh Harris	
Lord Markham	Lorraine Jackson	
Lord Kamall		

The CCG has no related party transactions with entities related to above individuals.

18. 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.

The functions, assets and liabilities of Berkshire West CCG transferred to Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board on 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.

19 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:

	2022-23 Target	**2022-23 Performance**	**Duty Achieved?**	2021-22 Target	2021-22 Performance	**Duty Achieved?**
Expenditure not to exceed income	312,155	312,155	Yes	1,283,407	1,283,316	Yes
Capital resource use does not exceed the amount specified in Directions	-	-	N/A	-	-	N/A
Revenue resource use does not exceed the amount specified in Directions	309,672	309,672	Yes	1,279,418	1,279,327	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	4,289	4,289	Yes	13,160	12,921	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).