Questions to OCCG to GB meeting 26 March 2015 from Oxfordshire Keep Our NHS Public

Q1	<u>Co-commissioning primary care</u> We have noted that in its response to our detailed questions (first submitted in November 2014) on co-commissioning of primary care, OCCG did not provide an answer to the final question: (e) Given the significant difference co-commissioning will make to the commissioning of healthcare services in Oxfordshire, how will OCCG improve their current practice and involve patients and the public in Oxfordshire in the crucial decisions that will need to be made? It is now apparent why OCCG evaded that particular question: there was no attempt to involve patient and the public in this decision. Indeed, a recent presentation (5 March 2015) on Primary Care Co-commissioning given to the City Locality Patient Forum made no mention of public and patient participation in the decision to recommend option 2. When questioned about the lack of involvement, Rosie Rowe told the meeting that this was owing to lack of time, and pressure from NHS England to make a response to their offer. a) Will OCCG accept that discussions were taking place with NHS England in the summer of 2014 on co-commissioning, and there was more than sufficient time to involve patients and the public? b) Will OCCG accept that public and patient involvement is not even a consideration in policy decisions, such as this? c) Will OCCG accept that the extent of any meaningful involvement of the public and patients is limited to the small numbers contributing to service re-design (MSK services) ? d) Will OCCG accept that despite repeated assurances that it is 'refreshing' its Engagement and Communications Strategy, this is evidently not a priority, and it still lacks a robust process for engaging the public and patients? Oxfordshire Clinical Commissioning Group (OCCG) is committed to involving patients and the public in the commissioning of healthcare services in Oxfordshire. NHS England offered CCGs across the country the opportunity to take on one of three different options in relation to co-commissioning of primary care, with two months to make a decision. OCCG consulted its member practices and based on their view OCCG decided that OCCG was not ready and processes were not in place to enable the organisation to take on full commissioning of primary care. Instead OCCG chose to take on option two, allowing the organisation to retain the current level of co-commissioning. This decision allows staff more time to analyse and plan for what taking on full co-commissioning would mean for the organisation, time to engage our staff, public and stakeholders on this development and if appropriate, time to develop a plan. OCCG delivered a presentation on co-commissioning and the three options to five out of six patient locality forums that were holding forum meetings during December 2014 and January 2015. An OCCG representative discussed the risks and benefits of each option and the impact of the decisions with the forums, taking questions. The representative explained that the organisation had taken a business decision to postpone the decision to take on full commissioning of primary care to allow more time to explore this development and OCCG would be working to involve patients, the public and stakeholders on this in the future.

	OCCG does involve the public in policy decisions. A recent example of this is the consultation on Patient Transport Services, where the public were consulted on changes to the eligibility criteria. OCCG does have to prioritise which issues or projects involve patient engagement due to the limitations of time and budget. However OCCG does benefit from six locality patient forums with direct links to our six clinical locality forums, where the business of the CCG is developed and debated. OCCG's Communications and Engagement Strategy is being refreshed and is currently out for comments with the public, patient representatives and our stakeholders. There has been a delay in refreshing this strategy while further development work was completed on an element of our engagement strategy, the way our Patient Locality Forums function and support the work of OCCG.
Q2	<u>Invoices to independent commercial providers</u> OCCG will be aware of public concern at the rise in the number of independent commercial companies commissioned to provide healthcare services to the NHS, especially those replacing in-house NHS services. a) In a single month (January 2015) OCCG paid close to £1 million to independent commercial companies such as: Berkshire Independent Hospital, Spire Healthcare, Circle Hospital, BMI Foscote Private Hospital, Horton NHS Treatment Sector, Ramsay Health Care, and Inhealth Endoscopy. How does OCCG justify commissioning independent commercial healthcare services that cost the public up to a £1 million a month? [http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2015/02/OCCG-Invoices-over-25000-Jan2015.pdf] There are two main reasons why the NHS commissions NHS services from private providers: • To ensure that there are a range of appropriately qualified and high quality providers to support patient choice; a key NHS Constitution right. • To allow for an appropriate flex in NHS capacity to meet demand at key points in the year. This has been evident in 2014/15 in the national drive to reduce NHS referral to treatment times. OCCG's spend with the identified providers is in support of these objectives. In the context of the current regulatory and legal framework for the NHS then any appropriately qualified provider is entitled to be considered for the provision of NHS services either under patient choice or through the competitive procurement of NHS service where this happens. Private providers of NHS services are paid the same national tariff rate for services under Payment by Results (PbR) as our NHS providers or market tested local prices for those that are outside of PbR. For context the OCCG's spend per month on healthcare services is approximately £54m. At £1m the spend on the identified providers represents 1.9% of this. b) Private provider, Nuffield Health has a two-year, £1 million contract with OCCG.

	What acute health care services does Nuffield Health, at The Manor hospital, Oxford provide that cannot be provided in our NHS acute hospital? None c) Will OCCG give a detailed description of the healthcare services it commissions from all independent commercial providers to enable patients and the public in Oxfordshire to understand what exactly is being provided on their behalf? At the time of writing we are currently agreeing contracts for the new financial year (15/16) so this information is not yet ready. We will: • Make available on our website a summary of the services provided by private providers in 2014/15 by 1st May 2015; and, • Do the same for our 2015/16 contract plans by 1st June 2015.
Q3	<u>Greater transparency</u> As part of the Government's commitment to greater transparency, there is a requirement to publish online central government expenditure over £25,000; this also applies to NHS bodies, such as OCCG. a) Will OCCG explain the invoices to Oxford University for 'other research expenses' amounting to more than £420,000 in January of this year? The CCG acts as the local host for NHS funded research grants awarded to Oxford University. The University applies for research grants, if awarded the funding is transferred to the CCG and we then pass it on to the University under the terms of each award. b) Will OCCG explain the nature of the 'participation fees' supplied to the CEO/Board Office by Oxford University Hospitals NHS Trust amounting to £37,130? This is our annual member contribution to the Academic Health Science Network which is hosted by the Oxford University Hospitals NHS Trust. Each member contributes to the running of the AHSN and in return the health system receives the benefits from its work.

Questions from other source to Oxon.gpc email address

Q4 In presenting his report, paper 15/19, please could the Chief Executive give indicative examples of ways in which GP practices/federations may be able to work with the Trusts in their role as Most Capable Providers of services for older people, and comment on how Patient Participation Groups can best prepare to provide input about their practice's particular role.

The GP Federations have been briefed on the Trust's role as Most Capable Providers of services for older people and we hope that they will be able to work together with the Trusts in developing new models of care for this population. Federations have started to develop relationships with Locality

Fora and will be working closely with their member practices to ensure that they communicate and engage their PPGs in their federated activity.

Q5 In presenting his report (included in paper 15/20), please could the Oxford City locality clinical director take note that there was in the event no opportunity for discussion of Dr Rosie Rowe's presentation on co-commissioning at the 5 March forum, because she had to leave for another meeting. As chairperson of a PPG, I do not understand how the obvious conflict of interest is to be dealt with, given that GPs are to be both managers of commissioning, and providers of services. Has the CCG any plans to brief PPGs properly about this?

At the meeting on 5 March 2015 Dr Rowe took questions as she presented her talk about co-commissioning and it ended with a Question and Answer session. Additional time was given to allow for these questions but due to the other items on the agenda there was not time for further group discussion. At this point Dr Rowe left the meeting to attend the Health and Wellbeing Board meeting. The governance arrangements for co-commissioning have now been agreed between NHS England and OCCG which address potential conflicts of interest and if PPGs would like more detail information or discussion about these arrangements Rosie Rowe would be happy to provide this.

Q6 What action will OCCG take to protect the closure of hospital kitchens at Oxford Health NHS Foundation Trust? As the petitions by Cllrs Hannaby and Meredith demonstrate, the local community, including the Trust's patients, staff and visitors, want the Trust to keep cooking fresh food on-site. Serving better quality, freshly cooked food will increase the number of people satisfied with their experience of hospital care and provide essential nourishment vital to recovery.

OCCG does not contract with Oxford Health at this level of detail but from a patient experience point of view, satisfaction with food is picked up through a number of routes including PLACE (patient-led assessments of the care environment) Audits and patient surveys. From a nutritional point of view, NICE is concerned with people having nutrition which meets their nutritional needs. It does not give guidance on where or how meals should be produced. Audits on compliance with NICE are undertaken. A briefing on this topic has been issued by Oxford Health NHS Foundation Trust and an extract is below:

"'Cook chill' meals are already served to most of our patients – at all of our mental health hospitals and around half of our community hospitals. Independent assessments carried out last year by 'PLACE' (patient-led assessments of the care environment) have shown that patients are satisfied with the quality of food served on these sites. By contrast, the worst scoring of any site was one where food was locally prepared.

Menus are designed and agreed with our dieticians to ensure good nutrition. Options are reviewed quarterly and updated to reflect preferences obtained from monthly patient food surveys, regular tastings, and feedback given to staff directly by patients. Staff work with nutritionists to ensure dietary requirements are followed, for example for patients whose sugar intake needs to be closely monitored. Patient feedback from recent monthly surveys has seen 10% or less rating the food as poor, and 90% rating it acceptable, good or excellent.

Adopting the same system across the trust guarantees consistency of quality, nutritional value and portion size. Meals will all be prepared offsite to recognised safety standards, reducing the risk of infection and exposure to allergens. This is a safer method for preparing food across a large organisation like ours and it allows us to maintain and monitor standards for all of our patients. It is

also more cost-effective to provide food in this way (at a third of like for like total cost of provision) and those savings, in these tough economic times, can be redirected into clinical services.

We recognise that at some hospital sites, patients and staff are used to having food cooked and prepared on site and that there may be some resistance to change. We believe, however, that a new unified system needs to be introduced for the benefit of both patients and the trust as a whole."