Questions to OCCG GB January 2016 meeting

Q1	<u>New Regulations on Tendering</u> In response to our previous question to the November board on how the new regulations on tendering (PCR2015) differed from existing guidelines from Monitor, your reply mentioned only the new £589k threshold for advertising in OJEU. But the differences appear to be much greater than this new contract threshold and directly concern OCCG's ability to award contracts to the NHS (sole provider). Monitor's guidance (Dec 2013) listed a number of circumstances in which commissioning bodies could award a contract to the NHS as a single provider, for instance, if only one provider 'had the necessary infrastructure' or could provide 'certain services' or where services 'need to be co-located' (page 241). But under the new procurement regulations the circumstances which would allow the option of single provider ('negotiated procedure without prior publication') are much tighter. Apart from certain technical reasons (no suitable tenders, absence of competition, involvement of works of art or intellectual property rights), the only really relevant circumstance mentioned in paragraph 32.2 is 'reasons of extreme urgency'. There are other limited single-provider options, for instance, in cases where it involves 'repetition of similar works or services' from an existing supplier (32.9). But, in general, these regulations are much stricter on the single-provider option that the previous section 75 and Monitor Guidelines. Does OCCG think that PCR2015 will further restrict its ability to award contracts to the NHS? The new regulations mean that all contracts over €750,000 (c£625,000) must be advertised in the OJEU and subject to competition. This now includes healthcare services where, under the old legislation this was discretionary (as 'Part B' services). It will be for the CCG to decide the award criteria for the contract and may take into account the need for integration of and continuity of other local NHS services as part of that. However, there is a requirement for the CCG to act transparently and apply equal treatment to all qualified providers. The CCG will no longer have the ability to award contracts to its deemed 'most capable provider' without having run a process as outlined above. Direct award of contracts will only be allowed where it has been determined that there is only one possible provider, where no suitable tenders have been received or in cases of extreme urgency. This is all likely to lead to more tendering activity.
Q2	<u>Proposals for Devolution and Integrating Commissioning in Oxfordshire</u> The Oxfordshire local authorities with OCCG and the Local Enterprise Partnership (LEP) have submitted a devolution proposal to central government. Given that a successful bid would lead to the development of a combined authority and create one commissioning system, patients and the public in Oxfordshire are understandably concerned about the

	implications for health and social care. A. What is the compelling evidence that a successful devolution bid will: i. cost less than the current systems; ii. give the public and patients in Oxfordshire better outcomes; iii. give the public and patients in Oxfordshire more democratic control (transparency and accountability) of the health and social care system; iv. ensure services are publicly commissioned and provided; and v. not increase levels of bureaucracy? B. Why could integration not be achieved within the current systems, with strong leadership and excellent cross-boundary working on behalf of patients? C. If a devolved authority fails financially: i. what penalties will it face; ii. would it be declared bankrupt; and iii. would it then be put out to tender to the private sector? We are focusing on applying to take on delegated responsibility for the commissioning of primary medical care and the greater integration of health and social care commissioning. This can all be achieved using current legislation and focuses on improving our current joint working with the County Council and NHS England. The public and patients think that services should be better joined up and this will be supported by integrating our commissioning. This is a part of the wider proposal for health and wellbeing in the full devolution proposal; this would ensure that all the NHS funding spent on Oxfordshire residents was controlled locally.
Q3	<u>MSK Business Case</u> One of the recommendations under option b of the business case to redesign and integrate MSK services was to 'approach existing providers for expressions of interest as the preferred commissioning solution'. a) Between them the current providers of the MSK service (OUHFT and OHFT) registered doubts about financial savings, governance arrangements, dedicated staffing and implementation of the proposed integrated MSK service. What steps have been taken to address these concerns? We have only recently received formal responses re the MSK specification from OHFT and OUHFT. They have identified areas they feel are not achievable in the new service but have not formally expressed concerns re the savings, staffing and implementation of the new service. The areas they have commented on are mainly relating to IT. b) What is the current status of the project? We have asked OUHFT if they would like to take part in the most capable provider assessment (they originally said they did not wish to provide the service) and are waiting for their answer to this request. c) The case for change (option b) was based partly on statistics in 'Higher Spend/Worse Outcome' analysis of Oxfordshire MSK services. The higher the elderly population within a CCG, the more likely the need for MSK services, with

	fewer successful clinical outcomes. What recognition is given to the age of the patient population in each CCG? We recognise that a large percentage of MSK services are likely to be used by people with degenerative joint disease and have calculated the potential usage using the Joint Strategic Needs Assessment (JSNA) data - age, sex standardised, as well as national data from the Department of Health. d) How are outcomes measured? The outcomes will be patient experience and an outcome measure called EQ5D. The patient experience measure will be agreed with the provider but will include some specific measures rated on a 5 point scale from Poor to Excellent for example and some text for patients to suggest changes/improvements or compliments. EQ5D is a validated outcome measure that a patient rates on a 5 point scale (the responses record five levels of severity: no problems/slight problems/moderate problems/severe problems/extreme problems) pre and post treatment/surgery in 5 areas which include mobility, self-care, usual activities, pain/discomfort, anxiety/depression. This is completed by the patient with support if required. e) The MSK business case also promotes, in a paragraph redolent of a marketing brochure, the lead contractor model developed by a private company: The Pennine MSK Partnership. What plans does OCCG have to implement the lead contractor model? This is in the business case but we have not pursued this model at the moment. f) Recommendation 4 (option b) states that 'opportunities exist to improve quality and *facilitate shift of activity and cost into self-management* by commissioning third sector services'. (P8) The shift to commissioning services to outside the NHS will mean that these services will no longer be available or viable within the NHS. What reassurance will OCCG give to patients that in future, when commissioning of these services from the third sector is stopped, as is likely when OCCG has to make additional cuts to their commissioning budget, that they will not then be expected to pay for these services from their own pockets, resulting in charging by stealth? The CCG supports where possible and appropriate involving the voluntary sector in delivering elements of care for patients where integrated with other NHS services. We would not expect patients to pay for these services themselves. g) Equally, with a shift of activity into third sector providers, what reassurances will OCCG give to patients that these services will continue to be available when they fail to be financially viable? If the providers become financially unviable the CCG would need to find alternative providers for the service.
Q4	<u>Commissioner Requested Services (CRS)</u> Premised on the financial failure of hospital trusts, Monitor has previously stated that the number of services that are currently designated as Commissioner Requested Services (CRS) would decrease as a result. a) Given that the mandatory protection of CRS will expire in April 2016, which CRS will

	OCCG continue to protect? b) Which CRS will OCCG omit from its new list? c) Where can the clinical evidence for these decisions be found? We are still working through our proposed CRS services at this point and therefore cannot give a full answer. This is being done as part of the contract negotiation round for 2016/17 with our providers. As Oxford University Hospitals NHS Foundation Trust became a foundation trust part way through 2015/16 all of its services have been designated CRS for the period of 1 year post authorisation. This means that we have until 31 September 2016 to agree what will be our CRS's moving forward with the Trust. Up until 31 March 2016, all of Oxford Health NHS Foundation Trust's services were deemed to be CRS services. New CRS designations will be agreed for the new contract year 2016/17. CRS designation allows services to be protected from a business continuity perspective and should guarantee the agreed level of service provision even if the provider is under financial duress. They are likely to be services that are high volume, fundamental to patient pathways and have limited ability to secure alternative provision. The evaluation of this will have a clinical perspective but will also have a wider operational basis.
Q5	<u>Outcomes Based Contracting</u> A £800 million contract to provide NHS care for older people in Cambridgeshire and Peterborough, deemed financially unsustainable after only eight months, was delivered through the controversial and largely untested-at-scale Outcomes Based Contracting (OBC) model. The OBC model currently underpins two major OCCG contracts for adult mental health and services for older people. a) What concerns do OCCG have about OBC in light of the failure of the Cambridgeshire and Peterborough contract? b) The OBC contract for services for older people has still not been agreed. Is the OBC model causing this delay? c) If not, what is causing the delay? d) How much money has been spent on the procurement process for this contract, to date? e) Initial analysis of the collapse of the Cambridgeshire and Peterborough contract reveals that warning signs of a lack of financial sustainability were apparent from the outset. OCCG claims that OBC locally will deliver 'greater financial stability for the health economy'. What safeguards has OCCG put in place to ensure that financial stability? f) The GB will be aware that the absence of clinical and financial evidence to support large scale adoption of OBC has been an issue of concern to us for many years. Will OCCG now reconsider its use of the unproven OBC model for the contract for services for older people? OCCG is committed to commissioning services that improve outcomes for the residents of Oxfordshire. OCCG used a different approach to securing the mental health outcomes based contract by working with current local providers. All parties are committed to

	working together and consider this is a better approach to delivering services for patients. The level of investment in the services was increased by circa £3.0m in 2015/16. The work on older peoples has not been delayed because it is an OBC model but recognition that the areas covered by this OBC link into all the wider work on Transformation, delayed transfers of care and access to urgent care. As previously reported from 2013/14 to 2015/16 we have spent circa £1.0 with a consortium of consultancy companies led by Cobic to take forward our work on outcomes based contracting. OCCG in partnership with Oxford Health NHS Foundation Trust held an event on Tuesday 23 February to celebrate the new partnerships who have come together to deliver better mental health services in Oxfordshire. The event was very well attended and has received good feedback. Information on this event can be found on the OCCG website at the following link: http://www.oxfordshireccg.nhs.uk/about-us/work-programmes/outcomes-based-commissioning/adult-mental-health-services-whats-new/
Q6	Transforming Health in Oxfordshire 'OCCG, along with Oxford Health NHS Foundation Trust (OHFT), Oxford University Hospitals NHS Trust, South Central Ambulance NHS Foundation Trust (SCAS), the Oxfordshire GP federations and Oxfordshire County Council (OCC) has set up a Transformation Board to drive forward the transformation of the health and social care system in Oxfordshire.' 'More specifically to bring together in one place all the projects, which will deliver significant change in the health and care system and provide a place for an in-depth discussion about new models of payment in the NHS; new model of provision (as detailed in the five year forward view) and system enablers (e.g. workforce, IT, assets).'[our emphasis] http://www.oxfordshireccg.nhs.uk/about-us/work-programmes/transforming-health-in-oxfordshire/ The discussion of 'new models of payment in the NHS' in the Transformation Board, ahead of any public or national discussion, raises a number of important issues for the public and patients in Oxfordshire. a) From where does the TB get its remit to have such discussions? The Board draws its remit from a common desire amongst the health and social care commissioners and providers to work together to address issues faced by the health and social care, improve the outcomes for the patients and ensure financial sustainability of the health and social care in Oxfordshire. In common with many large organisations/health systems, the Transformation Board provides a place for in-depth discussion about how to design and develop the next generation of integrated GP, hospital and social services and drive forward the transformation of services and care across Oxfordshire. Any proposals that come from these discussions would be discussed at the CCG and partner organisations' Boards; they would also be shared with the Health and Wellbeing Board and Health Overview and Scrutiny and Committee. b) What are the Terms of Reference for this Board? Terms of Reference of the Board are available on the CCG website at

	http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2016/02/Transformation-Board-Terms-of-Reference.pdf c) In the interests of transparency and openness, where can the Minutes of this Board be accessed? An update following each Transformation Board meeting is published on the CCG's website at http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2016/02/Transformation-Board-Update-January-2016.pdf d) It is anticipated that new care models will have the potential to lower costs by as much as '40%'. Where is the evidence for this figure? New models of care will be developed, tested and evaluated over the next couple of months. Business cases and consultation documents – yet to be developed – will include the analysis and evidence. e) Given the scale of government imposed financial challenges facing the NHS, with savings of £270 million by 2020/21 within Oxfordshire, and continuing massive cuts to local government, how can cuts to services be avoided? We do not envisage £270 million 'savings' coming out of NHS budget; rather, we intend to reallocate resources within the system so that it remains sustainable. f) What discussions have taken place with health unions and staff groups? We are not at a stage where we have developed any proposals/options. Any changes affecting staff (e.g. changes to roles, work patterns) will be discussed with unions and staff groups as per legislation and best practice. On a broader point, we are keeping our staff and partners updated using the established mechanisms within our individual organisations. g) One of the four tests mandated by government to be satisfied when service changes are proposed is 'strong public, patient and service user engagement'. Given the envisaged scale of changes to the current health and social care system, when will we have the opportunity to be strongly engaged, before any major decisions have been made that affect us significantly? 'Public, patient and service user engagement' for the transformation programme has started, with many individual initiatives (e.g. MSK service redesign, Townlands hospital), having stakeholders involved in their work. With regard to entirety of change, we have shared the 'storyboard', which paints a case for change and vision for the future of healthcare in Oxfordshire at the Health and Wellbeing Board, Health and Overview and Scrutiny Committee, locality meetings etc. In the very near future, we will be sharing out thinking on the approach, key decision areas and decision points, using the existing and creating new mechanisms for involvement, engagement and discussion. h) Another test is to demonstrate 'a clear evidence base' for the changes. Where is that evidence to be found? As explained above, new models of care are yet to be developed, tested and evaluated. Business cases and consultation documents – yet to be developed – will evidence.