Questions for OCCG Extraordinary Board Meeting 21 April 2016 from Oxfordshire Keep Our NHS Public

Budget

Q1

a) Is this Board meeting the only opportunity the public will have to comment on budget proposals that will have a significant and potentially devastating effect on the commissioning of their healthcare?
b) What consideration has been given to satisfying the government test that requires robust patient and public engagement when major changes are planned?
c) When will OCCG hold a public meeting (not a meeting held in public) to explain its position on the implications of its decisions on major changes to health and social care?

The funding available to OCCG in 2016/17 is an increase from 2015/16; the pressures arise as there are many demands on the additional funding available. OCCG must set a budget in line with its statutory duty and NHS England guidance. If major changes to services are required then these will be subject to patient and public engagement before being agreed.

Q2

OCCG revealed in March 2016 that it has to plug a £13m black hole in its finances and it cannot yet balance its books. David Smith has been reported as stating that 'there is more to do with the money than we are able to'. Direct cuts to services have not been ruled in or out.

a) How then does OCCG account for the statement in January 2016 that 'it was still forecasting to deliver its financial plan and surplus of £6.9m'?
b) What has changed?
c) Why were these changes not anticipated?
d) What impact will the latest financial positon have on patient services?
e) What criteria will be used to determine which services will suffer direct cuts, if that is what is decided?
f) What mechanisms are in place to enable OCCG to pay less for services, if that is the chosen option?
g) Which providers will be affected?
h) What impact will a reduction in payment to these providers have on patient care?
i) When will a risk impact assessment be carried out?

At previous meetings of the Board where we have considered the financial plan our conversations would have been about risk to that plan rather than a 'black hole in our finances'. As plans are developed, and particularly for the CCG as contract settlements are being negotiated there will be planning uncertainty and uncertainty equals risk. In March, prior to the agreement of contracts there was a £13m risk to the CCG in terms of a shortfall on its predicted savings plan. The size of that savings plan was determined to a large degree by the difference or 'gap' in respect contract offers with our major providers.

Despite this gap or risk the CCG was also planning to hold reserves as mitigation. As the value of these reserves are in excess of the risk then we could still forecast delivering our planned surplus.

The Financial Plan that was presented to and approved by the Board in April sets out how the CCG has utilised resources for 2016/17 and the inherent pressures therein.

The CCG, as with all NHS organisations, has to deliver savings on an annual basis as the demand and cost of demand for services exceeds available resources. The CCG's approach to identifying areas for savings is to use benchmark intelligence to identify where we may not be providing value for money, either through patient outcomes or through levels of expenditure. Where this leads to service change then this is subject to patient and public engagement, consultation and a business case process.

Savings on the price we pay for services can be delivered through local negotiation with current providers, supported with agreed approaches to manage and control costs or through a competitive procurement approach. All procurement exercises are advertised.

The CCG uses risk assessments in making its service change or procurement decisions.

Q3

Despite OCCG stating that £2m would the maximum it would spend on finding a remedy for DToC, it has since committed to yet more funding, without a noticeable drop in DToC numbers.

a) How can OCCG justify the continuing financial outlay, when there is no evidence of success?

There is evidence of success of this initiative. The number of DTOC reported is consistently at a level below the equivalent week last year and the number of bed days consumed by DTOC is also dropping. The DTOC initiative has shown a consistent reduction in the numbers (headcount snapshot) of people delayed in OUHFT from its introduction in December 2015. The year to date average on DTOC for 2016/7 is currently 117 whereas this figure was 154 for 2015/6

The total number of days delayed in the month has moved from 4,447 in November, 3,327 in December to 3,817 in January and 3,564 days in February. This was achieved whilst admissions were rising.

The most important evidence on patient outcomes cannot be so easily quantified. This is the benefit to patients of our moving them more effectively from being in the wrong setting. People are known to be at risk of deterioration through being in a hospital bed based setting and DTOC patients are confirmed by a multi-disciplinary team to be ready for discharge. There is clear research evidence that where older people are in hospital beds they can become more debilitated. As a result of our work patients and families have reflected positively on the improved environment once discharged. We know we are reducing the length of patients delay, we have seen an 11% increase in the proportion of delays which are less than one week. Based on the research evidence this should be improving outcomes for patients.

Q4

Of course we all want care that is co-ordinated and seamless, which will remove many of the frustrations when expectations of joined-up care are not met. However, it is widely acknowledged that there is a dearth of evidence on the impact of integrated health and social care. Analysis of case sites by the HSJ and the Kings' Fund showed great innovation and dedication to patient centred care but 'most failed to demonstrate systemic evidence of improved care outcomes and satisfaction levels.' Further, the evaluation of integrated care pilots by RAND Europe and the research briefing by the Social Care Institute for Excellence found the same to be true.

Additionally, there is evidence to indicate that attempting to integrate health and social care has little impact on reducing costs. A commission set up by the HSJ and Serco found no evidence in the assumption that 'providing more and better care for frail older people in the community and by integrating health and social care budgets will lead to any significant financial savings in the acute hospital sector.' http://www.rcpsych.ac.uk/pdf/HSJ%20OAP%20article%20-%20final.pdf

OCCG and its partners are assuming that the integration of these services will improve care outcomes and lead to financial savings.

a) Where is the evidence that supports OCCG's positon that its current plans to integrate health and social care will result in improved care outcomes?
b) Where is the evidence that supports OCCG's positon that the integration of health and social care budgets will reduce inefficiencies and result in financial savings?

The UK evidence is lacking because few places have done integration at scale over a long enough period of time. We know that evidence from the Kings Fund, National Voices and the Nuffield trust that there is better patient satisfaction and some evidence of better quality. International evidence is much stronger, particularly in the USA, New Zealand, Germany and Spain.

In addition we know from patients, the public and clinicians that there is waste and duplication in the way we currently provide services; making this more efficient would benefit patients and reduce costs.

Q5

Footprints: In the NHS England Planning Guidelines there are nine 'must-dos' specified for the footprints – https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

One of the nine is to 'return the system to aggregate financial balance'. This requirement comes at a time when NHS providers face the prospect of a combined deficit of around £2bn in 2015-16, during a period of government-imposed austerity in which funding increases have been severely constrained, and will be in future.

a) How can this be done without greater cuts to staffing, services and patient access?
b) How will the clinician-led CCG justify its failure to provide comprehensive healthcare services to patients and the public in Oxfordshire as a result of a NHS England directive?

c) When will OCCG start raising questions with NHS England about the centralised imposition to have Sustainability and Transformation plans that will be neither sustainable nor transformational?

As an NHS Statutory organisation the CCG is required to manage within its financial allocation and comply with guidance form NHS England.