Questions to the GB meeting July 2016 from OKONP

We are committed to being open and transparent but depending on the issues being raised this may best be done through discussion and conversation supported as necessary by written communication.

As stated at the Board meeting we offered to meet with representatives from Oxfordshire Keep Our NHS Public (OKONP) to be able to discuss with them the range of issues they had highlighted which are not always amenable to supplying only a written answer. We offered to follow up this meeting with a written summary of the discussion which we would then have been put on the website. We are disappointed that OKONP did not wish to take up the offer we made. Many of the points below relate to national guidance which, as a statutory NHS body, we are required to comply with.

Q1	<u>Finance and patient care</u> The following two concerns about finance were raised in a recent paper (8/6/2016) to the Transformation Board: • 'More evidence [needed] as to the savings that the changes will make. • Need more clarity on the financial model - is this affordable?' http://www.oxonhealthcaretransformation.nhs.uk/who-is-involved/transformation-board-meeting-papers/transformation-board-2016-06-14/81-paper-1/file The imposition of changes to health and social care nationally has been premised on the assumption that they will reduce the cost of services by delivering so-called efficiency savings. NHSE has decided - without supporting evidence - that moving healthcare into the community (with an emphasis on prevention and self-care) will be less costly than hospital beds. Owing to centrally controlled financial constraints on the NHS, local government and hospital trusts, cost-cutting has become paramount. The public needs to be reassured that the proposals for major changes in health and social care are clinically-led and based on a clear clinical evidence base. The new models of care are experimental, and the case for change in terms of patient care has not been made. a) How can OCCG justify significant changes to health and social care in Oxfordshire when it has insufficient evidence that they will result in the cost-cutting demanded by NHSE? b) Where are the calculations to be found that will reveal whether the financial model is financially viable? c) Will OCCG think again if there is a lack of evidence of savings, and the financial model is found to lack viability? d) What impact on patient care will this financial uncertainty and significant concerns about implementation costs have?

	e) Where is the evidence that these proposed changes will actually improve patient care? f) If there is insufficient evidence for improvements to patient care, will you abandon these plans? We have been openly discussing the Transformation Programme for many months now, including holding public events so that members of the public can help shape our developing plans. An Oxfordshire-wide public consultation for the future of health services in the County will be launched in December 2016 / January 2017. We are in the process of finalising our Pre-Consultation Business Case which will incorporate the detail including evidence, activity, and financial information.
Q2	<u>Bucks, Oxfordshire and west Berks (BOB) Footprint</u> The extensive list of questions below is indicative of the absence of public and parliamentary debate on footprints and STPs. Discussion and decision-making are being held behind closed doors, which does not bode well for the principles of accountability, openness and transparency. 1) The STP footprint does not have legal status. So where is the democratic mandate for its existence? 2) The emphasis in the planning guidance is now on collaboration across health and social care organisations. How does this square with the enabling legislation of the 2012 Health and Social Care Act that imposed further competition, internal and external on the NHS? 3) What is the point of BOB if each collaborator has their own plans, based on the needs of their local populations? 4) Will there be collective responsibility for BOB decisions? 5) When it becomes apparent that there is insufficient funding for each of the BOB collaborators to implement their individual local plans, how will disagreements be resolved? 6) As a footprint leader, will David Smith withdraw the veto from individual organisations (as Simon Stevens has suggested) if they fail to fall into line? 7) Where can we find the governance and representation arrangements for the BOB footprint? 8) What is the membership of the BOB footprint Board? 9) How many lay members are there on the Board? 10) How many trade union/staff side health workers are there on the Board? 11) What is the estimated cost of servicing the board each financial year? 12) From which budget will it be funded? 13) What is the chain of accountability? 14) How often does the Board intend to meet? 15) Can you confirm that the meetings will be publicly advertised in advance and there will be public access to them? 16) Where will the agenda, board papers and minutes be made available to the public? 17) What impact assessments have been carried out in relation to the operation of the STP?

	18) Where will the risk register, consultation plans and decision-making structures be published? 19) Has the Governing Body seen the full STP that was submitted to NHSE in June? 20) Does it have any concerns? 21) Does the Governing Body think that the interests of public accountability are served by the failure to submit the STP to the Oxfordshire Health Oversight and Scrutiny Committee? NHS guidance required us to work as part of the BOB STP footprint. Much of the service redesign required to meet the increasing demands on and challenges to services across the patch is at a county level. As such Oxfordshire's main contribution to the STP is our system wide Transformation Programme. To date the joint working has been undertaken building on pre-existing working relationships (eg the CCG Chief Executive and Chairs or the individual county level system wide fora such as the Oxfordshire Transformation Board). It is proposed that we establish a BOB Commissioning Executive and its proposed remit and membership will be considered by the OCCG Board on 29 September.
Q3	<u>Remuneration</u> a) What remuneration will David Smith receive for his appointment as leader of the BOB footprint? b) From which budget will this come? c) How many hours each month does David Smith expect to work on BOB matters? d) How can this post be reconciled with the full-time nature of his appointment as CEO of OCCG? Working with other NHS and public sector organisations is a core part of a Chief Executive's job and is accounted for in the organisational remuneration.
Q4	<u>Management consultancy</u> a) What is the total fee to Rubicon management consultancy for providing financial advice to the Transformation Board? b) How many days is the Rubicon contract for? c) By what process was Rubicon selected? d) How many other consultants are currently contracted to support the work of the Transformation Board? e) At what cost? Rubicon is contracted via the CSU and the costs are covered within our SLA with them.
Q5	<u>Back office and pathology consolidation</u> All STP areas, including BOB, have to report back by the end of July on opportunities to implement Lord Carter's recommendations on back office and pathology consolidation, with a particular focus on opportunities for quick wins with impact in

	2016/17 and 2017/18. [Strengthening Financial Performance and Accountability in 2016/17: NHSE, NHSI, 21 July 2016] a) How will OCCG exercise its current autonomy to select a CSU provider from the framework of approved providers? b) If the six other CCGs use a different CSU, how will a decision be reached over 'consolidation'? c) How will OCCG reassure the public that consolidation of pathology services will not lead to further privatisation, given the poor record of private pathology companies? d) What emerging risks and barriers have been identified? The Pathology work is part of the wider transformation work and if significant changes are proposed these would be subject to consultation. Any provider of services would have a contract with a clear specification and performance indicators. OCCG is working with the other CCGs for CSU provisions. We are agreeing joint specifications and will have a single evaluation as there are advantages to us to have the same provider.
Q6	<u>'Unsustainable' services</u> By the end of July STPs have been instructed to have 'reviewed services which are unsustainable for financial, quality or other reasons and identified the key priorities based on sustaining quality and improving efficiency'. [Strengthening Financial Performance and Accountability in 2016/17: NHSE, NHSI, 21 July 2016] a) Which services have been deemed 'unsustainable'? b) What criteria have been used to determine 'unsustainability'? c) Where is the documentation that shows the criteria are evidence-based? d) Plans have to indicate where these services will be re-provided. Where will these services be 're-provided'? e) Which 'key priorities' have been identified? f) What criteria have been used to determine the key priorities? g) Where is the documentation that shows these criteria are based on independent and sound evidence? h) What emerging risks and barriers have been identified? i) What concerns do OCCG have about the emphasis in papers from NHSE and NHSI on quick fixes, rapid progress, and the tight timetables for implementation, given the scope and scale of the major changes that will be imposed on local populations? The unsustainable services work is part of the wider transformation work and if significant changes are proposed these would be subject to consultation.
