NHS
Oxfordshire
Clinical Commissioning Group

Update from Oxfordshire Clinical Commissioning Group
February 2014

1. Authorisation Status

On 15 November Oxfordshire Clinical Commissioning Group (OCCG) submitted documentation relating to three outstanding conditions of Authorisation, both the Area and Regional Team of NHS England supported the submission.

NHS England's National Conditions Committee considered the application on 17 January and agreed to discharge the three outstanding conditions of authorisation applicable to OCCG in line with the Area Team recommendation that there is a move to in year management of operational performance.

This means that OCCG is now authorised in full and without any conditions.

2. Revised constitution

In November 2013 the OCCG Governing Body (GB) agreed constitutional changes to its senior management structure. This followed the recognition that the challenges facing health services in Oxfordshire were such that the OCCG should appoint a very experienced senior managerial executive to work in tandem with a Clinical Chair (a GP). A model used in more than 70% of CCGs across England.

NHS England, which has a statutory obligation to ensure that proposed changes to constitutions meet statutory obligations, agreed the changes, which took effect from 3 February 2014.

3. Appointment of Clinical Chair

The position of Clinical Chair was advertised widely to practicing GPs within Oxfordshire and a number of expressions of interest were received. All candidates attended a competency based interview with a panel Chaired by Louise Wallace, Lay Member of the GB with a lead role in championing patient and public empowerment. This was followed by the election process with member practices, which ran from Monday 13 January to Friday 24 January 2014. The process was supported by the Local Medical Committee's Chief Executive and turnout was 97%.

Dr Joe McManners was duly elected and his appointment endorsed by the Governing Body. As a result of this appointment Dr McManners has also been nominated as Vice Chair of the Health and Wellbeing Board. At the same time Dr Paul Park was ratified as Chief Clinical Information Officer for the CCG.

There is currently a vacancy on OCCG GB for the Lay Vice Chair role. Ian Busby, the previous Chair, has agreed to take on this position temporarily for three months in order to facilitate a handover and support the GB whilst open recruitment to the Lay Vice Chair post takes place. OCCG is most grateful to Ian Busby for steering the CCG through a challenging period and for his continued assistance.

4. Resignation of Dr Stephen Richards

Dr Stephen Richards has formally resigned from his role as Accountable Officer for OCCG. He continues his work as a GP in Goring and is actively considering how he can contribute to innovative change within the NHS to improve the quality of care patients receive.

Ian Wilson CBE, as Interim Chief Executive, will be taking on the role of Accountable Officer for OCCG temporarily, whilst a permanent officer is recruited.

OCCG wishes to formally thank Dr Richards for all his hard work and determination in building OCCG. He has been at the forefront of developing clinical commissioning within the county, indeed the country and has been unyielding in his dedication to improving care for patients within Oxfordshire.

5. The Financial Challenge

At 31 December 2013 (month 9) OCCG reported a projected £5.9 deficit. This is slightly better than the month eight position. The best case forecast outturn is a modest surplus of £0.6m while the worst case forecast outturn is a deficit of £12.6m.

The main driver of the deficit position is the year to date level of over-performance at the Oxford University Hospitals Trust (OUHT).

A new Quality Innovation Productivity and Prevention (QIPP) Programme Board has been established to tackle the financial challenge. QIPP plans have been narrowed down to the four projects which are most likely to deliver savings.

6. Outcomes based commissioning

OCCG has been progressing a new form of contracting to deliver improved outcomes for patients and greater financial stability for the health economy. This is called outcomes based commissioning (OBC). The innovative nature and scale of this proposed approach has required additional care and attention. Following a NHS Gateway review and feedback from the GB it has been agreed that:

1. In the area of maternity OCCG will review the feedback received and, in conjunction with the main provider, clinicians and patients, reconsider the advantages and feasibility of the application of OBC in this area.
2. OCCG will pursue a collaborative commissioning approach with Oxfordshire County Council (OCC) and a collaborative contracting route for older people with Oxford Health NHS Foundation Trust (OHFT) and OUHT for older people, with goals of explicit risk share, outcomes based contract performance management and incentives and service integration, with reserved commissioner rights to revert to open-market procurement should this pathway not be successful.
3. OCCG will pursue a collaborative commissioning approach with OCC and a collaborative contracting route for mental health with OHFT and its provider partners, with goals of explicit risk share, outcomes based contract performance management and incentives and service integration, and with reserved commissioner rights to revert to open-market procurement should this pathway not be successful.
4. An OCCG's procurement strategy will be developed; this includes the strengthening of the internal contracting and procurement infrastructure with a senior

appointment; and the strengthening of programme delivery governance and monitoring, with the establishment of a substantive Programme Management Office.

5. The collaborative contracting work is taken forward as part of the 2014/15 contracting round, is led by the Interim Chief Operating Officer/Director of Commissioning and Partnerships and is governed by OCCG's Senior Management Team with appropriate reporting into OCCG appropriate structures for any elements commissioned by OCC or jointly by OCC and OCCG.

7. Delayed transfers of care and winter pressures

A major cause of concern for OCCG remains the high level of delayed transfers of care (average of 142 since June 2013). The NHS and Social Care have been working together to explore the problems and extensive plans are in place to address this. Other issues include a failure to meet the four hour A&E target for some periods last year, an increase in multiple A&E attendances and in the proportion of attendances becoming admissions.

£10 million winter pressures money allocated before Christmas was helpful but implementation of actions to manage pressures was slow, resulting in a steadying of activity rather than any clear reductions. The winter has, however, so far been better than last in terms of providers' abilities to cope with demand, and providers should be thanked for all of their efforts to keep patients safe and improving care in this context.

One of the current problems Oxfordshire faces is the fact that some patients in our acute hospitals are offered a community hospital bed when they are clinically fit to be moved, but refuse it if it is not the closest to home. As a result some patients who are more unwell wait longer to be admitted to an acute bed. Whilst we would never move a patient against their will, it is important to remind people that 'choice' does not apply in such circumstances and we are asking people to accept what they are offered, for the benefit of more unwell patients.

8. Emergency abdominal surgery at Horton General Hospital

Please see separate paper on emergency abdominal surgery at Horton General Hospital.

9. A Call to Action:

OCCG embarked on a period of public engagement from 1 November 2013 to 7 January 2014 to gather feedback on OCCGs proposed strategic objectives. The engagement included a wide variety of methods including public meetings, an online survey, an online discussion forum and individuals also had the opportunity to give direct feedback via email, phone or freepost. The engagement project focussed on informing the Oxfordshire population about local financial pressures and sought the public's views on how we might address the challenge by making changes to the services that are commissioned.

A report has been complied and will be available on OCCGs website (www.oxfordshireccg.nhs.uk); the suggestions and comments from the public have been used to assist OCCG in creating a five year Strategic Plan and delivering a two year Operational Plan.

The issues of major concern to the public are that:

1. OCCG is open and transparent about the financial challenge faced and the plan is open and honest about the need for a deficit budget this year, and the scale of the financial challenge facing the organisation.

2. If OCCG has to cut services to make savings, it is open about this and the plan does not propose cutting any services, but does set out ambitious plans for service transformation that will increase efficiency.

3. Whilst there is support for the patient outcomes in the outcomes based commissioning plans, OCCG should not rush into this new form of contracting. A rigorous review of this work is being undertaken and that will inform the next steps in relation to commissioning for outcomes. OCCG is committed to ensuring that the good work undertaken with partners to date to understand the joint responsibility for delivering better outcomes for patients in a more efficient way is reflected in the use of the standard contracts for 14/15.

4. Care closer to home is supported, but not to the detriment of the quality of care. The plans for development of integrated community teams and EMUs will deliver enhanced quality and enhanced outcomes to patients.

5. OCCG needs to change the attitude of the public from “fix me now” to individuals taking joint responsibility for their health with their GP. This is a longer term goal, and OCCG will strive to deliver this via the work of the equality and access teams in each locality, through Patient Participation Groups and through the self-management components of the Better Care Fund and Long Term Condition programmes.

6. OCCG needs a comprehensive all ages education programme about how to use the NHS. The Equality and Access teams are beginning to address this with some early work to raise awareness in those communities least familiar with the NHS, in partnership with key general practice partners in areas of high immigration and deprivation.

7. OCCG should maximise the potential of technology to free up GPs time to deliver face to face care. The Better Care Fund plan will see increased investment in the County Council’s Alert service, and the Long Term Conditions programme proposes that the CCG reviews how they can work with partners in the Academic Health Science Network to exploit the potential of new, and potentially more effective telehealth solutions. The CCG locality teams are actively supporting development of initiatives such as patient access to records, on line appointment booking and text message appointment reminders.

8. OCCG should reduce duplication and waste. The achievement of integration improvement intervention is designed to reduce hand offs between organisations and so to eliminate bureaucracy and waste, both for the system and for individual patients and service users.

10. OCCG Strategic Plan

OCCG has agreed six objectives for its Five Year and Two Year Plan, which have been revised in the light of the considerable public feedback through A Call to Action. The agreed objectives are for OCCG to:

1. Be financially sustainable.
2. Be delivering fully integrated care, close to home, for the frail elderly and people with complex multi morbidities.
3. Have a primary care service that is driving development and delivery of this integrated care, and is itself offering a broader range of services at a different scale.
4. Routinely enable people to live well at home and to avoid admission to hospital when this is in their best interests.
5. Be continuing to provide preventative care and to tackle health inequalities for patients and carers in both its urban and rural communities.
6. Be providing health and social care that is rated amongst the best in the country for all its citizens in terms of quality, outcomes and public and patient satisfaction with services

First informal sharing of the Plan took place with NHS England on 24 January 2014. The Plan has been shared with partners including the County Council and providers to ensure that it is compatible with their strategies and plans and discussions with them will continue. The first formal submission of the Plan to NHS England is on 14 February 2014, followed by feedback. The final Plan must be submitted to NHS England by 4 April 2014.