Oxfordshire Clinical Commissioning Group (OCCG)
Shadow Governing Body Structure

1. Introduction

The following outlines the rationale for changes made to the structure of the final shadow Governing Body for Oxfordshire Clinical Commissioning Group through the transition year April 2012 to March 2013. The final structure, also outlined below, reflects national guidance and input from those who responded to the ‘Towards the creation of a shadow Governing Body’ consultation; a report of which is available in Appendix A.

2. Changes to proposed structure

- A Chief Operating Officer is no longer in the structure; in recognition of the need for very senior manager involvement in the shadow Governing Body there will be two Directors roles: a Director of Commissioning Implementation and a Director of Quality and Innovation, both will be voting members.
- There will be two representatives from the County Council - the Director of Public Health and the Director of Social Care; this is in recognition of feedback from Oxfordshire County Council and the clear strategic direction for closer alignment of Health and Social Care Commissioning.
- There will be three lay representatives, rather than the two recommended in National Guidance, one of which will be the Chair of the shadow Governing Body. Significant concerns were raised by members of the public about the need for more lay representation. All three will be voting members of the shadow Governing Body.
- A Medical Director will replace the proposed Deputy Accountable Officer role; this change was made in recognition that the Accountable Officer (who will be a clinician) required additional clinical support as well as the Medical Director providing clinical Leadership to the Locality Clinical Directors (previously named Locality Leads). The Medical Director will also take the lead role for developing OCCG strategy.
- The Nurse Lead and Secondary Care Clinician will be voting members of the shadow Governing Body; this decision is in response to concerns raised by members of the public around the need for wider clinical input into commissioning.
3. Final structure

Oxfordshire Clinical Commissioning Shadow Governing Body

Key:

- **Chair**: Lay Directors (voting members x 3)
- **2 x Lay members**
- **6 x Locality Clinical Directors**: Locality Clinical Directors (voting members x 6 – the 7th is the Medical Director)
- **Accountable Officer (clinical)**
- **Medical Director**
- **Chief Finance Officer**
- **Director of Quality and Innovation**
- **Director of Commissioning Implementation**
- **Secondary Care Doctor**
- **Nurse Director**
- **Director of Public Health (Partnership appointment with Oxfordshire County Council)**
- **Director of Social Care (Partnership appointment with Oxfordshire County Council)**
- **Practice Manager (from Oxfordshire GP practice)**

Version 1 27/3/12
Appendix A:  
Oxfordshire Clinical Commissioning Group (OCCG)  
Towards the creation of the Shadow Governing Body by 1 April 2012: Consultation Report

1. Introduction

The Oxfordshire Clinical Commissioning Group (OCCG) has to create a shadow Governing Body, or Board, that is “Fit for Purpose” and is in place in time for the authorisation process later in 2012. The shadow Governing Body needs to be in place by 1 April 2012 to enable OCCG to build a track record of performance in commissioning. National guidance around identifies key roles and minimum requirements for the shadow Governing Body of a clinical commissioning group (CCGs); however beyond that, CCGs are able to define their own Governing Body.

The role of the OCCG shadow Governing Body is to ensure that OCCG has appropriate arrangements in place to exercise the organisation’s commissioning responsibilities “effectively, efficiently and economically and in accordance with the generally accepted principles of good governance and the constitution of the CCG”¹ and take it through the organisational process.

A proposed structure for the shadow Governing Body has been developed and consulted upon. What follows is a report of the outcome of the consultation including the engagement process undertaken, identified stakeholders, results and recommendations.

2. Background

2.1 What was the purpose of the consultation?

The purpose of the consultation was to:
- Provide an opportunity for the stakeholders² to give their views and feedback on the proposed shadow Governing Body structure for OCCG.
- Develop local knowledge about might need to be taken into consideration when developing the structure of the shadow Governing Body for OCCG.
- To raise awareness of the developing OCCG

2.2 Why undertake this consultation?

Clinical commissioning reflects the Government’s desire to have more decisions about healthcare made a local level. Therefore informing and engaging with local stakeholders should be at the centre of the developing OCCG. It is this with this ethos in mind that OCCG has sought feedback from stakeholders to inform the final structure of its shadow Governing Body.

¹ Extract from ‘Towards Establishment: creating responsive and accountable clinical commissioning groups’
² Stakeholder: a person or group with a direct interest, involvement, or investment in something.
2.3 Consultation duration
The consultation was launched on 9 February 2012; it closed to external stakeholders on 24 February 2012 and to GPs on 29 February 2012.

2.4 How will the feedback be used?
The responses gathered over the course of the consultation will help to inform and shape the structure of OCCG’s shadow Governing Body and subsequent final structure when OCCG received formal designation as the statutory for commissioning healthcare in Oxfordshire from April 2013. Views were sought from a wide range of stakeholders but the final authority to design and form the shadow Governing Body resides with the GP community.

3. Stakeholders
The key stakeholders identified for this consultation included:
- GPs
- Practice Managers
- Local Medical Committee
- Buckinghamshire and Oxfordshire PCT Cluster
- Oxfordshire County Council
- Secondary care providers (Oxford University Hospitals, Oxford Health and Ridgeway Partnership)
- NHS Commissioning Board (NHSCB) / South of England Clustered Strategic Health Authority (SHA)
- LINks & HOSC
- Members of the public

4. Engagement process
A number of different methods were used in order to source feedback on the proposed structure as outlined below:

- **Locality Leads**: Locality Leads invited comments from their constituent practices and the proposed structure was raised at each Locality Meeting. In the case of the City locality the meeting was immediately after the previous Transition Board and so no discussion possible but all practices were invited to feedback individually and were reminded before the deadline.
- **Email**: personal invitations to participate in the consultation were sent to Chief Executives of commissioning and provider organisations as outlined in section 3. Email invitations also went to the Chair of the LINk and HOSC; to all practice managers for their participation and for them to distribution to their Patient Participation Groups and to the OCCG public distribution list (from those who had attend previous OCCG public events or registered an interest in received information about OCCG).
- **Online engagement**: an online was set up on Talking Health; this included a short survey of two questions (see section 5.4) and free text options; a briefing document was also displayed which included the proposed structure. An email was sent to over 700 people that were registered on Talking Health to receive surveys.
5. Key findings

5.1 Primary Care

6 responses were received directly from practices additionally further summary responses were gathered from discussion at meetings. Overall there was broad support for the structure with the following specific comments made:

- No specific concerns were expressed from the SE locality regarding the structure but concerns were expressed about pressing ahead with the structure before the Bill is passed.
- Support for a practice manager representative to be on the Programme Board from three practices and from the Practice Manager Forum. One response wanted this not to be at the expense of a clinician.
- NOLG, SWOLG, WOLG and NEL localities support a Practice Manager being a member of the Governing Body. Responses were split as to whether this role should be a voting member with some members of WOLG (5 out of 9 practices) supporting them having a vote.
- One practice in the North and the SWOL reported support for Public Health to be represented in its own right on the Governing Body.
- One City GP raised concerns about conflict of interest for any member of the Governing Body and suggested that a condition of selection / election should be that candidates agree to sell any shares in relevant companies that they own.
- One City GP raised concerns about lack of opportunity for discussion locally because of tight timescale.
- NOLG, SWOL and NEL locality members felt strongly that the Chair should be the best person for the job. Some members of NEL felt it was important it should be a lay person. Most practices in the WOLG locality supported a clinical chairman.
- WOLG locality felt the Deputy Accountable Officer should be elected outside of the existing leads.
- NOLG locality members felt that the Quality Lead role should be filled by the best candidate whatever their clinical background. SWOL felt the Quality Lead should be a GP in order to provide gravitas and credibility. WOLG were happy for the Quality Lead to be a nurse and for that person to have voting rights.
- One sessional GP responded to the consultation expressing concern about the lack of engagement with sessional GPs in Oxfordshire and highlighted the benefits they would bring to OCCC.

5.2 Commissioners

No comments received.

5.3 Secondary care providers

Oxford Health is generally supportive of the proposals. They raised the question about tenure of Board member which is particularly important for the lay members and secondary care consultant. In addition clarification was sought about the secondary care clinician role and the benefits of having a mental
health specialist, someone whose expertise is in psychiatric liaison or nurse consultant.

5.4 Local Authority
The response from Oxfordshire County Council expressed support for OCCG. They are keen to develop the relationship and see OCCG as one of their major strategic partners and refer to the increasing emphasis of the need for collaboration between CCGs, Social Care and Public Health. For this reason they concluded that their representation should be increased to two members on the Governing Body. This should be the Director of Public Health and Director of Adult Social Care.

5.5 Public
95 responses were received via Talking Health. This demonstrates a real public interest in the OCCG and its development.

Respondents were very equally split as to whether the membership and voting arrangements of the proposed shadow governing body would meet the need of engaging with patients and communities as outlined below:

**Question 1: Do you think the membership of the OCCG shadow governing body will meet the need of engaging with patients and communities?**

<table>
<thead>
<tr>
<th>Option</th>
<th>Results</th>
</tr>
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<tbody>
<tr>
<td>Yes</td>
<td>50% (47)</td>
</tr>
<tr>
<td>No</td>
<td>50% (47)</td>
</tr>
</tbody>
</table>

**Question 2: Do you think the voting arrangements of the OCCG shadow governing body will meet the need of engaging with patients and communities?**

<table>
<thead>
<tr>
<th>Option</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>45% (41)</td>
</tr>
<tr>
<td>No</td>
<td>55% (50)</td>
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</tbody>
</table>

However, despite this the majority of responses given via free text (58 out of 95 respondents submitted free text information) have illustrated that respondents still have a lot of concerns around the proposed structure; its membership; voting arrangements and the way feedback was sought. There were not many supporting comments, less than five responses indicated that they felt proposals would be sufficient.

One might expect only those who disagree with proposals to submit further free text information highlighting their concerns. However, having analysed each response, raising concerns around the proposals is not dependent on whether a respondent agrees or not.

The headline analysis below attempts to demonstrate the feedback that has been submitted and is supported by respondent quotes.
5.5.1 Membership and Structure

- Concern was raised that the structure is unbalanced and would not facilitate the public voice to be heard.
- Respondents felt more lay reps are needed and that they needed to have a mandate for their role.
- Lay representatives would need support and training to ensure that they could have influence in this arena. If lay reps were not effective there is a concern that this will make decision making process weak and not ensure that public voice is represented here.
- Respondents also felt that membership was dominated by the professional view and based heavily on one clinical view of GPs. Comments indicated that Non-execs could also play a part here in balancing with lay point of view.
- Concerns about the conflict of interest between GPs - business interests but patient advocates. Proposed membership does not allow this to be diluted by having more clinical reps from other areas.
- Concerns about the conflict of interest of having a practice manager role which is essentially a business manager; what is their function on the shadow Governing Body?
- There were also concerns that there is not enough public information available about how the structure will function and be appointed too. The theme around lack of information runs throughout the consultation as a whole.

Supporting quotes:

“Too few lay members which leaves patients vulnerable to the vagaries of personal opinions of doctors.”

“The OCCG shadow governing body appears to have around 18 members, of which only two are lay members. I feel this is inadequate to provide patients with a strong independent voice. It is important to realise that this organisation is run for (and funded by) members of the public and a stronger representation is needed.”

“The structure seems to be very dominated by professional posts. I would prefer to see the lay membership increased from the current 2 positions. I am concerned that the voice of those with long-term conditions, including users of social care should be very clearly represented and heard.”

“The two lay members should, in my opinion, encourage the participation of local communities by seeking to ensure that the Local HealthWatch both inform and educate local people, as to the nature of the healthcare decisions which the OCCG would have to make, and also to ensure that there be strong multi-disciplinary commissioning across Health and Social Care in support of those with Learning Disabilities, Long term conditions, etc., across the full age range.”

“We seem to have moved from a board with balance introduced by non-executive directors, recruited to high standards and bringing wisdom and experience, to paying lip service to public engagement through just two lay members with no apparent indication of the requirements for eligibility or any apparent role in relation to the general public.”
“The list of board members seems to be very small and limited in scope. Better that it has a group of Directors (paid) and appointed competitively - as in most organisations - and a group of Non-Exec Directors - representing all sorts of different groups - but who hold the board to account. This is a time-honoured way of doing things in the private sector, the voluntary sector and the public sector. It’s worked to date - so why change it?”

5.5.2 Engagement process

- The general feeling from respondents was that there needed to be more information about the methodology of how engagement with the public would take place in OCCG. Perhaps we have lost impetus on work on communications and engagement undertaken.
- Respondents indicated that they were not sure how the structure / membership / voting arrangements would facilitate engagement.
- Views might be influenced by the way in which the feedback process was undertaken. Many respondents felt that this process to seek views on proposals was too top down, too time limited, and against the grain as OCCG have already indicated that they wanted to take engagement seriously - references to comms and engagements strategy consultation. People felt that this process did not demonstrate commitment to engagement and instead promoted something that lacked meaning and was tokenistic.

Supporting quotes:

“The voting arrangements via this consultation exercise appears to be a little short at 14 days and may not stand the test of time (and may give the impression of a rushed or railroaded process). Thoughts as to reassurance of the public that the process would stand scrutiny should be considered, in the event should this need to be justified or be called in to question.”

“It has been some months since the communications exercise took place to look at structures. It is disappointing that there now appears to be a very short time left to flesh out the shadow process.”

“There is insufficient detail or direction as to how the Shadow Board will engage with the patients and communities; is this mechanism already in place? or is it for the Shadow Board to define the Terms of Reference.”

5.5.3 Voting Arrangements & Decision Making:

- Respondents indicated that they felt decision making as proposed would be dominated by one clinical view point and this was not good.
- They also indicated that lay reps should have influence here.
- Decision making should be transparent and use objective evidence. Again, concern that this would take place if only one clinical profession dominated the vote.
- Focus on voting rights - proposals were not conducive to a democratic process.
- There was a clear message that other health professionals must have a voice.

Supporting quotes:
“Because of the unbalanced nature of the committee/board as outlined in Q1 an organisation loaded towards the interests of the profession may not always put meeting the needs of patients and communities as a priority. This must not happen. The Act specifically addresses the problem inherent in the NHS from its inception i.e. that a certain professional elite acting almost as "medical mafia" have retained control of the service often to the detriment of patients and communities”

“I think all on the board should be able to vote including a local hospital consultant and the County Council representative, but that they should be excluded from voting on commissioning and contracting issues where they may be a provider and that includes all the GPs. There needs to be a safeguard to ensure the GPs don't just empire build to keep money for themselves and that there are no other conflicts of interest.”

“It seems to me that the GPs will always be in the majority. This will not be democratic in any sense. Instead of introducing commissioning decisions based on clinical views, decisions will be made from just one clinical viewpoint and excluding other key clinicians from a voting right. Furthermore key clinical groups like AHPs are excluded altogether.”

5.5.4 General comment:
- There were concerns around the timescales in which the governing body needed to be set up and if there was enough time to do this properly. Concerns were raised about needing to promote joined up decision making.
- The positives must be emphasised. There is a great interest in OCCG and appetite for more engagement and more information. However, lots of respondents felt that they were not able to answer fully regarding how membership and voting arrangements would facilitate engagement as there was simply not enough information about processes.

6. Conclusions

The draft structure for the Governing Body attracted a significant interest from the public and others. Overall, there was a good deal of support, however, a number of specific issues were raised that that need to be considered by OCCG Transition Board:

- OCCG to consider how it could include wider clinical input; should the Nurse Lead and secondary care clinician be voting members? (taking into account conflict of interests being managed). More clarity required about the secondary care clinician and whether this would be open to mental health and other disciplines.
- OCCG to consider length of tenure for all posts on the Governing Body.
- OCCG to consider function and role of practice manager on the shadow Governing Body. Clear support demonstrated by practice managers and some practices but concerns raised by members of the public.
- OCCG to consider number of representatives required from OCC.
- OCCG to consider if the Deputy Accountable Officer should be elected outside of the existing leads.
OCCG to consider potential conflict of interest and the suggestion that members standing for election have no conflicting financial interests.

All efforts should be made in the future to give more time for feedback from members of the public in accordance with the communications and engagement strategy.

How to broaden the engagement of primary care clinicians, in particular sessional GPs.

OCCG to publish more information about the appointments process when it is available.